ZSFG JOINT CONFERENCE COMMITTEE MEETING

APRIL 27, 2026

MEDICAL STAFF REPORT

Contents:

1. Family and Community Service Report
2. Family and Community Medicine Rules and Regulations
3. Privilege lists:
    a. CPC NP 103 Privilege List
4. Medical Staff Bylaws Amendments

ZSFG CHIEF OF STAFF-OPEN SESSION ACTION ITEMS

Presented to the JCC-ZSFG April 27, 2026
April 2026 MEC Meetings

Clinical Service Report and Rules and Regulations:

1. Family and Community Medicine Service Report
2. Family and Community Medicine Rules and Regulations and summary of changes

Credentials Committee-Privilege List

1. CPC NP 103 Privilege List

Medical Staff Bylaws:

1. Medical Staff Bylaws Amendments

ZSFG CHIEF OF STAFF REPORT

Presented to the JCC ZSFG on April 27, 2026
April MEC Meetings

Family and Community Medicine (FCM) Clinical Service Report: Teresa Villela, MD
The highlights of the FCM report are as follows:

I. Vision
The Family and Community Medicine (FCM) Service is driven by a mission to support healthy families and vibrant communities through comprehensive, equitable, full-spectrum care. This mission underlies all inpatient, outpatient, urgent care, community, and teaching activities, reinforcing a commitment to patient-centered, and collaborative practice across the ZSFG system.

II. Scope of the Clinical Service
The Family and Community Medicine (FCM) is the largest primary care site in San Francisco Health network, providing a broad range of clinical services including the Family Health Center, Family Medicine inpatient service, urgent care, skilled nursing facility services, labor and delivery support, special clinical services, and care for patients at Mental Health Rehabilitation Center. The FCH service includes management of a high-volume adult inpatient service with approximately 1,200 admissions per year. The urgent care center receives about 2,709 patient visits per month, the 4A Skilled Nursing Facility has an average daily census of 22 patients and Family Health Center has approximately 52,000 patient visits per year. The Bridge Clinic at Family Health Center started as a pilot program in 2017 and has grown to serve over 1,000 unduplicated patients in 2025-2026, providing services for patients with substance use disorders. The Gender Clinic Family Health Center launched early this year and provides consultation visits for transgender, nonbinary, and gender expansive people within a primary care setting.

III. Leadership, Faculty and Residents
The department is led by a combined DPH–UCSF leadership structure, including the Service Chief, administrative leadership, the residency program director, clinical medical directors, and nursing and administrative managers across care areas. The Family and Community Medicine leadership includes Teresa Villela, MD, who serve as Chief of Service; Lydia Leung, MD. who serves as Vice Chief of the Service, Cory Johnson, MD who is the new residency program director, Margaret Stafford, MD as FCM inpatient Medical Director, Kohar DerSimonian, MD as Medical Director of Adult Urgent Care Center, and Christine Pecci, MD as Prenatal and Birth Center Director. Training programs include Family Medicine residents, medical students, family nurse practitioner students, and fellows. Residents rotate throughout nearly every ZSFG department, gaining experience in a wide array of clinical settings. Faculty and leaders also participate in multiple hospital and medical staff committees supporting quality initiatives, education, ambulatory operations, and system flow.

IV. Performance Improvement and Patient Safety (PIPS) Initiatives
The service completed and launched several PIPS efforts this year. One major initiative examined inpatient length of stay, identifying disparities between median and average stay driven by high-utilizer patients, and developing interdisciplinary interventions to improve transitions and reduce re-admissions. Another major PIPS project in urgent care focused on correcting the financial losses from out-of-network encounters. Through redesigned workflows, patient education materials, and improved referral systems, the department significantly reduced denied billing and improved alignment of patients with their appropriate coverage. Additional improvements included expanding APPs procedural privileges, as of January 2026 the goal was reached, with APPs achieving 95% splinting and 82% incision and drainage procedures. The 4A Skilled Nursing Facility is advancing patient workflow improvements. The implementation of the Cut Hypertension partnership at FHC has helped reduced the blood pressure control gap among Black/African American patients.

V. Research
Family and Community Medicine (FCM) maintains an active research enterprise focused on primary care innovation and health equity. Research programs include Evidence to Drive Equity, the Person-Centered Reproductive Health Program, the Social Interventions Research and Evaluation Network, the Center for Excellence in Primary Care, and the CTSI Community Engagement and Health Policy program. Several faculty members across FCM team received distinguished awards and honors across the FCM team.

VI. Financial Report
The service operates with an annual budget of approximately $16.4 million. About $9 million of this comes from residency affiliation funding, which directly supports residency operations with the remainder covering departmental expenses.

VII. Summary
Challenges and Opportunities-The department continues to navigate several ongoing challenges and areas of opportunity. Securing adequate space for the Family Health Center remains an unresolved issue and still pending. There are also transitions in leadership across the FCM residency program. Additionally, the department faces pressures related to maintaining

competitive, market-driven salaries. Broader structural challenges including budget constraints, persistent inequities within the communities served, and the continued stressors related to immigrant backlash.

Strengths- Despite these challenges, the department continues to benefit from several key strengths. It has collaborative and talented leadership teams that provide stability and vision, supported by ongoing backing from department leadership and the associate dean. The mission-driven commitment of staff, faculty, administrators, and residents—rooted in strong relationships and deep community trust which further reinforces the department's continued success.

VIII. Family and Community Medicine Rules and Regulations – The Committee members expressed deep gratitude to Dr. Teresa Villela's leadership and the Family and Community Medicine team for their outstanding work , and commitment to delivering high-quality care. A motion for the committee to approve the updated FCM Service Rules and Regulations was made and approved. Approval from the Health Commission is requested for the Family and Community Service Rules and Regulations.

Family and Community Medicine

Biennial Report to Medical Executive Committee

April 13, 2026

Teresa Villela, MD Chief of Service
Lydia Leung, MD Vice Chief of Service

FCM@ZSFG Vision

Healthy Families
Vibrant Communities

ZSFG Family & Community Medicine Organization Chart, 2026

UCSF FCM Department Chair

MAHONEY, MEGAN

Executive Cabinet

Vice Chair for Academic Affairs: Isabel Lee
Vice Chair and ZSFG Chief of Service: Teresa Villela
Vice Chair of Research: Christine Dehlendorf
Vice Chair of Research: Danielle Hessler Jones
Vice Chair, Fresno FCM: Ivan Gomez
Vice Chair of Opportunity, Leadership Development & Engagement: Monica Hahn

JACKSON, SHANICE – Associate Chair, Finance & Administration

LEE, CHRISTINE – Executive Assistant, Parnassus

VILLELA, TERESA – Vice Chair & ZSFG Chief of Service

FINANCE & ADMINISTRATION

- **SEGOVIA, JOEL** – Operations & Finance Manager
- **BREKHUS, CLAIRE** – ZSFG Coordinator
- **LEE, TIFFANY C** – Post Award Analyst

CLINICAL SERVICES

ESTRADA, SELENA – Exec Asst., Credentialing Coordinator, Special Projects Manager

Family Health Center (FHC)

Name	Role
DAY, KIRSTEN	Co-Medical Director
UY-SMITH, ELIZABETH L	Co-Medical Director
NGUYEN, SEN	Assoc Medical Director
LABAT, EBONY A.	Clinic Administrator
VAOVASA, EDEL	Coordinator
AVILA GONZALEZ, IVET	Data Analyst/Patient Advisory Board Liaison
CABRERA MARQUEZ, ADRIANA	Patient Navigator

Family Medicine Inpatient Service (FMIS)

Name	Role
STAFFORD, MARGARET P	Medical Director
PEI, APRIL	Asst. Medical Director
DELOS SANTOS, REINA P.	Coordinator
TBA	Patient Navigator

Skilled Nursing Facility

Name	Role
VILLELA, TERESA	Interim Medical Director
TBD	Nurse Practitioner (DPH)

Adult Urgent Care Center (UCC)

Name	Role
DERSIMONIAN, KOHAR	Medical Director
LIANG, CARMEN WAH	Assoc. Medical Director
LAGRIMAS, TANYA	Assoc. Medical Director
SCIANCALEPORE, JOSEPH	Clinic Operations Manager
LEE, AMY H	Nurse Manager

Behavioral Health Center Primary Care Services

ZSFG Faculty

COFFA, DIANA A
DEHLENDORF, CHRISTINE
CHU, CAROLYN
DAY, KIRSTEN
FRANKS, ARIEL
LEE, ISABEL D
LEUNG, LYDIA C
MIRRER, MEREDITH
MOONEY, CLAUDIA DIAZ
PECCI, CHRISTINE CHANG
POLLOCK, LEALAH C
SNYDER, HANNAH R
TAPIA, MANUEL
VENER, MARGO H
WOLFE-MODUPE, FLO
WORTIS, NAOMI

27 MSPs – Fixed & Variable

Prenatal and Birth Center

EDUCATION & TRAINING

FCM Residency Program

Name	Role
JOHNSON, CORY	Residency Director
LEUNG, LYDIA	Assoc. Residency Director
JACKSON, RANDY	Assoc. Residency Director
TBD	Director of Behavioral Services
KRISTINE ROSHANI	Residency Manager
YOUNG, ROBIN	Data/ Evaluation Coordinator
ELIZABETH DEELY	Residency Program Coordinator

Residents
15 - PGY 1
15 - PGY 2
15 - PGY 3

FCM Pre-doctoral Education

WORTHEY, IRINA N – Curriculum Program Administration

National Clinician Consultation Center

Name	Role
CHU, CAROLYN	PI and Chief Clinical Officer
BOSTIS, CHRIS	Clinical Director
GOLDHAMMER, BRENDA	Administrative Lead

Chief Residents

Name	Role
TBD	Chief Resident
TBD	Chief Resident

Fellowships

Fellowship	PIs
Int. Med. for Urban-Underserved Research	PI: Flo Wolfe-Modupe; PI: Kevin Grumbach

RESEARCH

Center for Excellence in Primary Care

Name	Role
WILLARD-GRACE, RACHEL I.	CEPC Director
BODENHEIMER, THOMAS S	Founding Director
KONG, MARIANNA	Physician Practice Transformation Specialist
SHARMA, ANJANA	Patient Engagement in Primary Care

PERSON CENTERED REPRODUCTIVE HEALTH PROGRAM

Name	Role
DEHLENDORF, CHRISTINE	PI and Director
FOX, EDITH	Unit Manager

Health Advocates & Financial Fitness

Name	Role
GOTTLIEB, LAURA M	ZSFG Faculty / Health Advocates

ZSFG Research Faculty & Staff

Name	Role
SHARMA, ANJANA ESTELLE	ZSFG Faculty

SARNAIK, SHASHI AJITKUMAR – Research Community Program Manager

ZSFG Family & Community Medicine Organization Chart, 2026

Draft 04/2026

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SARNAIK,SHASHI AJITKUMAR — Research Community Program Manager

ZSFG Family & Community Medicine Organization Chart, 2026

Draft 04/2026

FCM@ZSFG

- **Clinical**: Family Health Center, Family Medicine Inpatient Service, Urgent Care Center, Skilled Nursing Facility (4A), Prenatal Partnership Program, Primary care for patients at Mental Health Rehab Center (MHRC)
- **Education**: Students, residency program, fellowships
- **Community and leadership**
- **Research**

Family Medicine Inpatient Service

Family Medicine Inpatient Service - #'s

Family Medicine Inpatient Service

- **1200+ admissions each year**
- **Staffing**
  - 2 FM Attendings
  - 3 Senior FM Residents - days
  - 2 First year FM Residents - days
  - 2 FM Residents - nights
  - Nurse practitioner weekdays
  - +/- 4th year student
- **Evening shift attending** 6pm – 10pm

Family Medicine Inpatient Service Census

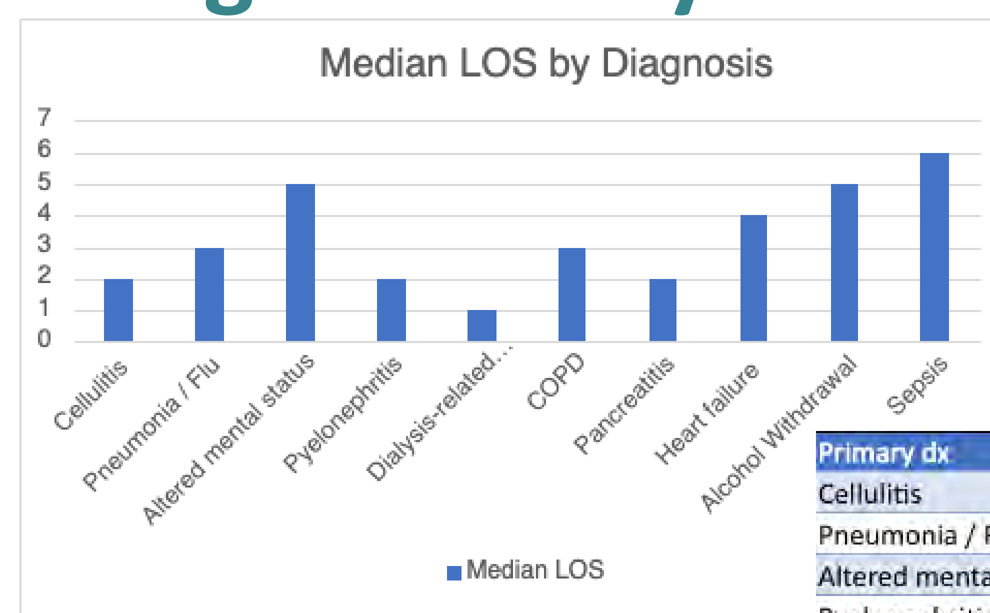
FMIS average monthly census 2025

35
30
25
20
15
10
5
0

25-Jan 25-Feb 25-Mar 25-Apr 25-May 25-Jun 25-Jul 25-Aug 25-Sep 25-Oct 25-Nov 25-Dec

Avg monthly census (QDC) — Ave monthly census (internal data) — Target

Family Medicine Inpatient Service Length of Stay



Primary dx	Median LOS	Average LOS
Cellulitis	2	3
Pneumonia / Flu	3	4
Altered mental status	5	20
Pyelonephritis	2	4
Dialysis-related complications includ	1	3
COPD	3	5
Pancreatitis	2	4
Heart failure	4	5
Alcohol Withdrawal	5	5
Sepsis	6	11
GI bleed	1	2
AKI	2	4
Fracture	5	6
Cirrhosis-related complications	5	5
Afib	6	7

Family Medicine Inpatient Service Staff

- Medical Director: **Margaret Stafford, MD**
- Assistant Medical Director: **April Pei, MD**
- Nurse Practitioner: **Nasrin Aboudamos**
- Coordinator/coder: **Reina Delos Santos**

Family Medicine Inpatient Services – Who We Are

- Multidisciplinary team building
  - Pharmacist, Medical Social Worker(s), RN Care Coordinator, Patient Navigator, Physical Therapist, Residents, Attending Physician
- Duty hours
  - Schedules, communication, hand-offs
  - Shared census: FCM, IM, Cardiology, Hospital Medicine Faculty Service

Adult Urgent Care Center

Adult Urgent Care Center

New Location: Building 5, 1st Floor, Unit 1E

成人緊急護理中心

新地址：5號樓，一樓，1E單元

Centro de Atención Urgente para Adultos

Nueva Ubicación: Edificio 5, Primer Piso, Unidad 1E

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

? 628-206-8052

ZUCKERBERG SAN FRANCISCO GENERAL Hospital and Trauma Center

Adult Urgent Care Center Leadership Team

Medical Director: **Kohar DerSimonian, MD**

Assoc Medical Director: **Carmen Wah Liang, DO, MPH**

Assoc Medical Director: **Tanya Lagrimas, MD, MPH**

Nurse Manager: **Amy H. Lee, RN, BS**

Clinic Operations Manager: **Joseph Sciancalepore, MPH**

Charge Nurse**: Nhu Doan, RN, BS**

Nursing Director: **Merjo Roca, RN, BA**

Adult Urgent Care Center

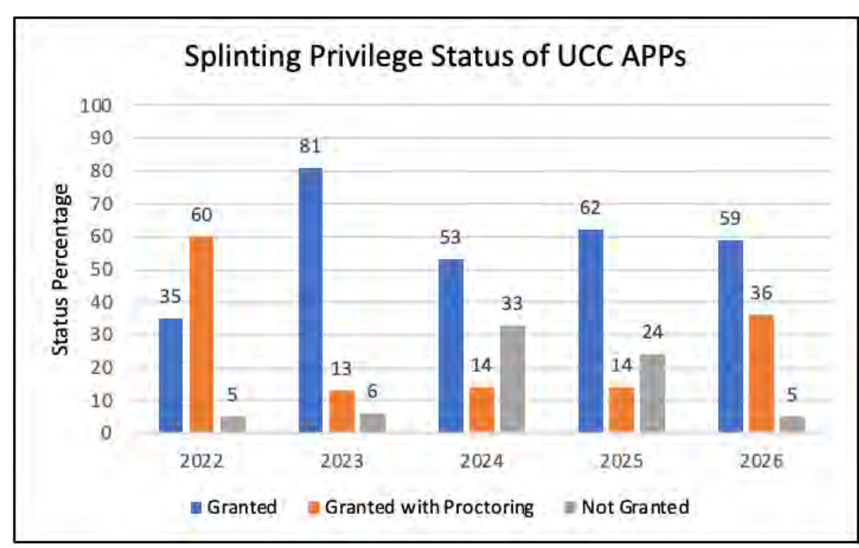
2025 Monthly Visits and Percent Visits with Lead Time <= 90minutes

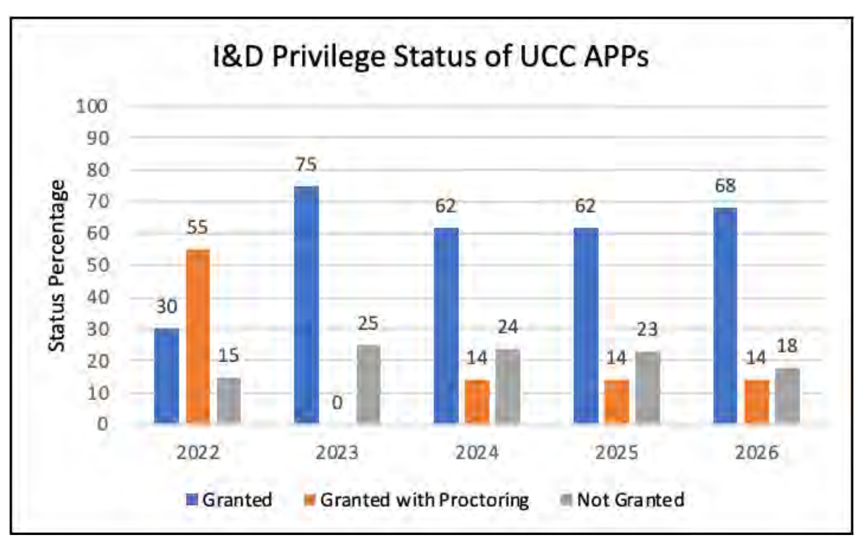
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Grand Total	3466	2783	2855	2824	2740	2542	2764	2687	2619	2478	2251	2509
ED Follow up	687	506	553	535	498	472	504	522	535	327	374	477
% <= 90 min	73%	71%	73%	73%	74%	74%	75%	75%	76%	77%	76%	72%

Average **2709** patient visits per month (compare with 2024: 2874)
74% of visits with lead time ≤ 90 min (compare with 2024: 78%)
499 patients per month referred from ED (compare with 2024: 574)

Importantly, the UCC leadership team and staff developed and implemented an out-of-network workflow that resulted in cost avoidance of ~ $1.7 million in unreimbursed care in the last year

Adult Urgent Care Center: focus on interdisciplinary practice





- **Goal:** Increase the percentage of advanced practice providers (APPs) with privileges *granted* or *granted with proctoring* for splinting and incision and drainage each to 78%

NOTE: in the above graphs "not granted" is a stand in for "has not applied for the privilege" not that the priv has been denied

- UCC Leadership team collaborated to create a process for establishing standard operating guidelines, provide educational presentations coupled with skill-building and practice sessions.

- As of Jan 2026, the goal was reached with ***95% for splinting and 82% for I&D***

4A Skilled Nursing Facility

4A Skilled Nursing Facility

- Short-term skilled nursing facility
- Post-acute care for patients hospitalized at ZSFG who are otherwise unable to access SNF care, due to
  - Payor, Immigration, or Housing status
  - Substance use disorders
  - Multiple advanced chronic illnesses
  - High needs (antibiotic or wound care frequency, wound vacs, nutrition support, insulin management, specialty follow-up, hemodialysis)
- Important resource for maintaining flow out of hospital
- 26 patient beds (reduced due to construction)

4A–Skilled Nursing Facility

- Average daily census 22
- Admit and discharge average of 6-8 patients per week
- Average LOS is 38 days; median LOS 20 days
- Improvement: Patient Flow
  - Average discharge time goal: **12:01PM**
  - Average % of discharges before 2PM goal: **70%**
- Improvement: Staffing
  - Filling vacant positions
  - Workflow efficiencies
  - Staff development

4A Skilled Nursing Facility Staff

Interim Medical Director: Teresa Villela

Nurse Manager: Joyce Loyola, BSN, RN

Nursing Director: Tanvi Bhakta, MSN, RN, CNL

Social workers: Vanessa Kamekona, MSW

4A–Skilled Nursing Facility – Who We Are

Interdisciplinary care:

Pharmacists, RNs, LVNs, PT, OT, Nutrition, Wound Care, Activity Leaders, Consulting Services

Prenatal and Birth Center

- Directors: **Christine Pecci, MD**
- Family physicians from Castro Mission HC, Potrero Hill HC, Silver Avenue FHC, ZFGH Family Health Center
- Work in collaboration with Ob/Gyn and CNM services
- Yearly course in Advanced Life Support in Obstetrics (ALSO) and participation in Birth Center trainings, guideline development/implementation, and quality improvement

Family Health Center

ZSFG Family & Community Medicine Org. Chart, 2026

Family Health Center
at Zuckerberg San Francisco General Hospital

San Francisco Health Network
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Blake Gregory, MD
SFHN Primary Care Director

Teresa Villela, MD
ZSFG, UCSF FCM
Chief of Service

Carol Taniguchi, PNP-C, MS, MPH
SFHN Primary Care Deputy Director

Saba Shahid, PsyD
SFHN Primary Care Director of Behavioral Health

Rachel Clee, LMFT
Assistant Director, Primary Care Behavioral Health

Sharon Keyes
Nurse Manager

Kirsten Day, MD
Medical Co-Director
Director of Operations

Sen Nguyen, MD
Associate Medical Director
Residency Liaison

Elizabeth Uy-Smith, MD, MPH, MAS
Medical Co-Director
Director of Clinical Care & Practice Performance

Schedule & Program Analyst
Edel Vaovasa

La'Jae Loville
Health Worker Supervisor

Saidah Shabazz
Practice Manager

Lisbet Gamez
Eligibility Worker Supervisor

Angelica Bollard, RN
Cristina Punzalan, RN
Charge Nurses

Ana Del Rosario Murray, LMFT
Director of Behavioral Health

Health Workers
Melodes Ewnetu
Jo Gray
Zavoncia Shankle-Sadler

Administrative Assistant

Norma Rodriguez

Eligibility Workers
Maria Holly Acoba
Sybil Christopher
Jackie Davis
Tamara Johnson
Grace Lunardelli
Angelica Magallon
Veronica Martinez-Rios
Alma Olmedo
Nancy Pamatian
Tamara Thomas

Vacant (1)

Senior Eligibility Worker
Jiaming (Gavin) Liang

Medical Evaluation Assistants

Sandeep Bhuller
Alexis Blueford
Federico Carvajal
Na (Anna) Du
Karen Duong
Ericka Escobedo
Joan Garchitorena
Jasmine Garcia
Claudia Gonzalez
Janelle Leung
Lisda Mazariegos
Paola Molina
Shayna Samoa
Karna Thomas
Evangelina Tongol
Josefina Valis
Cindy Wong
Christine M. Wu
Christine Y. Wu

Vacant (1)

Registered Nurses

Elizabeth Aquino
Jennifer Chiu
Isela Monteiro
Rica Tano
Josefina Tolosa
Cuimin (Minnie) Li
Linda Truong (Diabetes)
Melisa Vargas (Prenatal)

Vacant (2)

As Needed RN
Franco Salvador

Vacant (2)

Behavioral Health Clinicians
Lucia Ramos, ACSW
Farnaz Mohiuddin
Latreasa Session, ACSW

Behavioral Assistants
Tatyana Dubrovsky
Gia Thompson

Clinic Administrator
Ebony Labat

Clinical
Nurse Practitioners (7)
Physician Assistant (1)
Faculty PCP (25)
Fellows (3)
Resident PCP (45)
Attendings (19)
Psychiatrist (1)
Newcomers Health Program

Pharmacists
Jennifer Cocohoba
Betty Dong
Jaekyu Shin
Denise Yeung

Nutritionists
Teresa Chan
Maria Gutierrez
Angel Nguyen

Vacant (2 Nurse Practitioners)

Quality Improvement

Data Analyst II
Ivet Avila-Gonzalez
Patient Navigator
Adriana Cabrera
Data Analyst I
Camella Haecker

Newcomers Health Program

Program Manager, **Sammi Truong**
Clinical Services Coordinator, **Alyssa Daulat, MSW**

Health Workers
Alta Bayanjargal
Omar Cortez
Ibtisam Dahud

Data & Admin Specialist
Amanda Pornas

Updated 12.17.2025

Family Health Center

LEADERSHIP TEAM

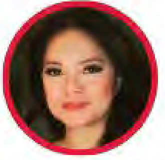
KIRSTEN DAY
MED DIR OF OPERATIONS
SHE/HER

ELIZABETH UY-SMITH
MED DIR OF CLINICAL CARE & PRACTICE PERFORMANCE
SHE/HER

SEN NGUYEN
ASSISTANT MED DIRECTOR
SHE/HER

SHARON KEYES
NURSE MANAGER
SHE/HER

ANGELICA BOILARD
CHARGE NURSE
SHE/HER



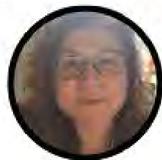
CRISTINA PUNZALAN
CHARGE NURSE
SHE/HER

HATTIE GRUNDLAND
NP LT LIAISON
SHE/HER

EBONY LABAT
CLINIC ADMINISTRATOR
SHE/HER

EDEL VAOVASA
SCHEDULING & PROGRAM ANALYST
SHE/HER

LA'JAE LOVILLE
HEALTH WORKER SUPERVISOR
SHE/HER



LISBET GAMEZ
HOSPITAL ELIG WRK SUPERVISOR
SHE/HER

SAIDAH SHABAZZ
PRACTICE MANAGER
SHE/HER

ANA MURRAY
BEHAVIORAL HEALTH SUPERVISOR
SHE/HER

Family Health Center Full Scope Primary Care

52,000 patient visits per year

- Chronic illness Care
- Prevention
- Well-child Care
- Reproductive Health
  - Prenatal care
  - Family planning, including IUD, Nexplanon, medication abortion
- Urgent Care for Children and Adults
- Behavioral Health
- Office Procedures
- Home Care
- Telehealth

Family Health Center Special Clinical Services

- Care of families affected by HIV
- Bridges Clinic – Substance use disorders treatment
- Integrative medicine and acupuncture
- Psychosocial medicine – primary care integration
- Family Care and Reproductive Health Clinic
- Oral health screening and fluoride varnish application
- Youth and young adult services
- Team Lily at FHC
- Black centering group visits new parents
- Geriatric consultation
- Diabetes team care
- Gender affirming primary care
- Spine health
- PharmD supervised anticoagulation management
- Refugee clinic; Newcomers Health Program
- Group visits: Diabetes, Hypertension, Trauma/Stress, Pain management

Family Health Center - Special Clinical Services pt 2

- Care of families affected by HIC
- Bridges Clinic – Substance use disorders treatment
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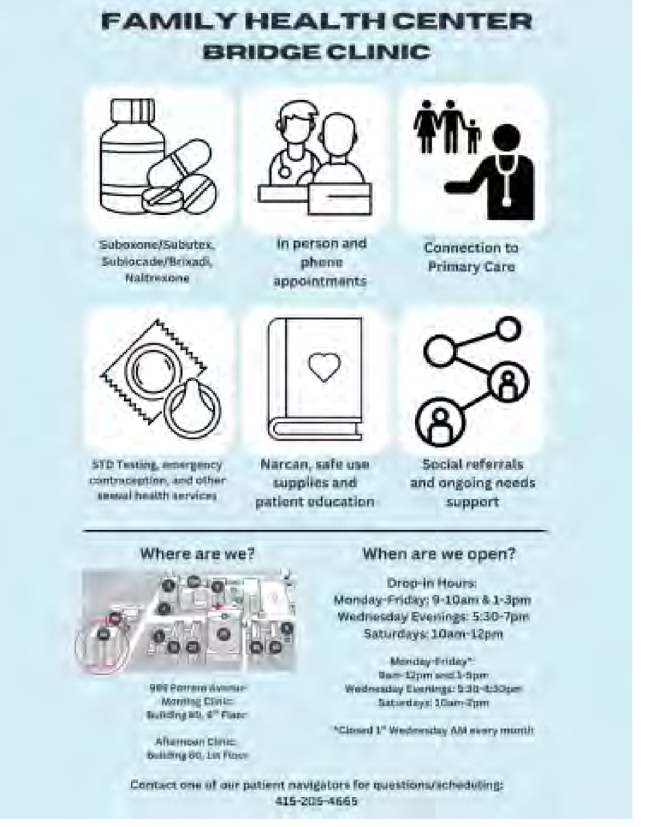
- PharmD supervised anticoagulation management
- Refugee clinic; Newcomers Health Program
- Group visits: Diabetes, Hypertension, Trauma/Stress, Pain management

Bridge Clinic* at Family Health Center

*open access, evidence-based care for substance use disorders

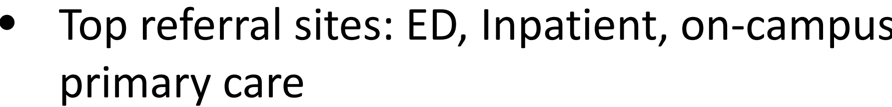
- Pilot program 2017 (½ day/wk)
- Expanded quickly with funding from Prop C and 2024 SF Opioid Settlement
- 2025: six days per week
- Diagnosis, Motivational interviewing, ***Medication treatment,*** Facilitated referrals to residential treatment & behavioral health, Harm reduction

Unduplicated Patients
2023-24: 599
2024-25: 861
2025-26: ?



Bridge Clinic

Hannah Snyder
    Medical Director
Alanna Labat
    Practice Manager
Jon Oskarsson
    Director of Nursing, Pos Health/W86
Ayesha Appa
    Clinical Lead, Health Access Point (HAP) at Pos Health/W86



- Top referral sites: ED, Inpatient, on-campus primary care
- Patient Demographics
  - Male 65%, female 33%
  - Race: White 39%, Latine 29%, Black/AA 25%, Asian 4%, Other 4%
  - Experiencing homelessness: 40%

Gender Clinic at Family Health Center

- **Needs assessment**
  - 83% satisfied with care at FHC
  - 56% satisfied with gender affirming care
  - 93% felt gender identity supported by PCP
  - 55% felt PCP was knowledgeable about gender affirming care
- Consultation visits for transgender, nonbinary, and gender expansive people within a primary care setting
- February 2026; 2 Monday evenings per month

Family Health Center

FY23-26 Strategic Goals:
Close disparity gaps for all the metrics from people of all backgrounds. Achieve or exceed the equity performance goal for all clinical driver metrics for Black/African American patients

FHC % patients with Hypertension and BP control <=140/90

80%
70%
60%
50%
40%
30%
20%
10%
0%

FHC goal (65%)

Jan 2025 Feb 2025 Mar 2025 Apr 2025 May 2025 Jun 2025 Jul 2025 Aug 2025 Sep 2025 Oct 2025 Nov 2025 Dec 2025 Jan 2026 Feb 2026 Mar 2026

All pts B/AA pts

CUT HTN collaboration begins Jan 2025

Bi-weekly check-ins with CUT HTN team begin

FHC HTN Equity WG participation decreases

SFHN selects B/AA HTN as driver

CHARMED study participation and training

In-Depth review of FHC, RN Long show rates with FHC Leadership

HW, Z, begins FHC, RN Long reminder calls

R3 PDSA intervention for peer-peerCUT HTN referrals

Mid-year QI check-in during all staff meeting. (11 pts to disparity closure)

Healthy Hearts Kick off; patient incentives 'Cardiovascular Health Month'

R2 resident training on Driver metrics; FHC Provider meeting requesting charts routed to analysts for resource linkage

Family Health Center: hypertension

- Continue to meet overall BP control ratel at or above 65%
- February 2026, met goal to reach B/AA HTN control of 65%. 10% improvement in one year!
- SFHN primary care goals to reduce disparities across DPH clinics provided a shared framework that kept staff aligned and focused on the same priorities
- In April 2025, a barbershop opened in the Bayview community where patients could check their blood pressure outside of the traditional clinic setting. This was a long planned for and awaited moment.
- In July 2025, the FHC QI team and leadership identified nurse visits and home BP monitors as process metrics that could support efforts
- In January 2026, an All-Team meeting QI check in announcing that BP control for B/AA patients improved but 11 patients were needed to reach the goal of 65%.
  - Increase awareness of HTN control for B/AA pts as a driver
  - Reinforce team-based care dynamics

Family Health Center Patient Advisory Councils

- Practice improvement advisors
- Patient education materials
- FCM Residency Program selection
  - Conduct Interviews
  - Serve as Members of Selection committee

FHC annual retreat 2026

Our FHC Values

Create a SAFE and HEALING ENVIRONMENT for our patients and each other.

Build a CULTURE that WELCOMES DIVERSITY and helps people to ADVANCE.

Promote RESILIENCE.

Provide WHOLE PERSON-CENTERED, COMPASSIONATE, ACCESSIBLE, and EQUITABLE care.

ADVOCATE for our patients and each other.

RESPECT our patients and one another.

FAMILY HEALTH CENTER

FHC

Everyone is a TEACHER and a LEARNER.

Establish a culture of IMPROVEMENT and GROWTH where we WELCOME CHANGE and VALUE FEEDBACK to promote change.

Learn from our MISTAKES and hold ourselves ACCOUNTABLE.

SUPPORT each other to find JOY and MEANING in our work.

COLLABORATE with our patients and each other.

EMPATHIZE with our patients and one another.

Annual Retreat 2026

Family Health Center

ZSFG Annual Equity Award Recipient

June 3, 2006

Family Health Center: environment and safety

Family Health Center: Environment & Safety Acknowledgement

Thank you:
Jeff Schmidt, Angelica Journagin, Chauncey Jackson, Sabrina Robinson and their teams

Education: Medical Students

- **Margo Vener, MD** Vice Chair for Education
- **Erica Brody, MD** FCM student programs
- ~ 38 Medical Students at ZSFG
  - 6 on FCM Clerkships at FHC and 6 1st & 2nd Year Medical Students on rotation
  - Longitudinal Clinical Experience—4th year
  - Bridges Curriculum
  - 3 on rotation every 4 weeks on FM Inpatient; ~ 26/year
  - Model SFGH Program (with Pediatrics, Internal Medicine, Surgery)

UCSF University of California San Francisco

Education: UCSF

- UCSF Family Nurse Practitioner Students clinical practicum (7 per year)
- Collaborative
  - Primary Care Research Fellowship (DGIM)
  - Primary Care Addiction Fellowship (IM)
- **Fellowship in Integrative Medicine for Underserved Populations**

Education: Regional Projects

- Faculty Development Fellowship for Northern California (Dr. Isabel Lee & Dr. Catalina Triana)
- Clinician Consultation Center. Management of HIV, perinatal HIV, pre-and post-exposure prophylaxis; substance use disorders (Drs. Chu and Goldschmidt) http://nccc.ucsf.edu/

Education: SFGH FCM Residency Program

Program Director:

Cory Johnson, MD

Associate Program Directors:

Randy Jackson, MD

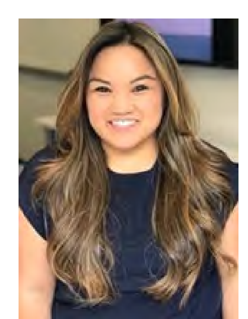
Lydia Leung, MD

Director of Behavioral Sciences:

TBD

Residency Manager:

Kristine Roshani



FCM Resident Assignments

Vermont

San Bruno

22nd Street

Building 3

Building 100

Bldg 5

Service Building

Bldg 4

Building 90

Bldg 1

Building 9

Bldg 40

6M Pediatrics: **3-4 residents**

4A SNF: **2 residents**

Emergency Dept: **2-3 residents**

Med-Surg FMIS: **9 residents**

Family Health Center: **45 residents**

Acute Care for the Elderly **1 resident**

Pediatric Nursery **1-2 residents**

Pediatric Ward **1-2 resident**

Birth Center: **4 residents**

ICU **1 resident**

FAMILY & COMMUNITY MEDICINE RESIDENCY PROGRAM 2025-2026

PGY 1 Class of 2028

Mel Calica
MD (she/her)
Tufts Univ.

Becca Dendy
MD (she/her)
Univ. of Arizona

Fabi Fernandez
MD/PhD (he/him)
UCSF

Torrey Guan
MD (he/him)
St. Louis Univ.

Ashish Gurung
MD (he/him)
Dartmouth

Su Bin Hahn
MD (she/her)
USF Health Morsani

Karyssa Harris
MD (she/her)
Univ. of Rochester

Yuto Iwakuma
MD (he/him)
Univ. of Kansas

Patricia Luzuriaga
MD (she/her)
Chicago Medical School

Erick Masias
MD (he/him)
Northwestern

Donia Momen
MD (she/her)
Chicago Medical School

Natalie Pearlman
MD (she/her)
UC Davis

Edgar Quintero
MD, MPH (he/him/él)
UC Irvine

Matthew Rodriguez
MD (he/him/siya)
Sidney Kimmel

Eyouab Tadesse
MD, MS (he/him)
Wayne State Univ.

PGY 2 Class of 2027

Adwoa Agyarkowah
MD, MS (she/her)
Howard

Norman Archer
MD (he/him)
UCSF

Thu Dao
MD (she/her)
Georgetown

Tam Du
MD (she/her)
UC Riverside

Jacob Gomez
MD (he/him)
Univ. of Rochester

Hana Habchi
MD, MPH (she/her)
Univ. of Alabama- Birmingham

Nidhi Kotian
MBBS (she/her)
K.J. Somaiya Medical

Jennifer Lai
DO (she/her)
Western Univ. of Health Sciences

Sandy Li
MD, MPH (she/her)
Howard

Liana Mixson
MD (she/her)
Univ. of Wisconsin

Mary Nguyen
MD, MSc (she/they)
Univ. of Arizona

Drym Oh
MD, PharmD (she/her)
Rutgers

Diana Perez
MD (she/her)
Columbia

Yvette Ramirez
MD (she/her)
Rush Univ.

Carlos Torres
MD, MA (he/him)
Univ. of Wisconsin

PGY 3 Class of 2026

Maria Acevedo
MD (she/her/ella)
UTH Houston

Josh Campista
MD (he/him/él)
UCSF Davis

Paula Cepeda
DO (she/her)
Touro, CA

Lawrence "Larry" Garcia
MD (he/him)
Northwestern

Indigo Gill
MD, MS (she/her)
Univ. of Rochester

Ron Hart
MD (he/him)
UC Davis

Tresne Hernandez
MD (they/them/elle)
Univ. of Rochester

Joe Morales
MD (he/him)
UA Tucson

Keonnie Parrilla
MD (he/him/él)
UT Southwestern

Sean Poole
DO (he/him)
Touro, NV

Megan Rodrigues
MD (she/her)
Univ. of Kansas

Nehal Sadi
MD (she/her)
Saint James

Tri Tran
MD (he/him)
Howard

Jacq Truong
MD (she/her)
Drexel

Dave Wiegn
MD (he/they)
Brown

Community Engagement

- FHC Community Liaisons: Drs. Manuel Tapia and Elizabeth Uy-Smith
- Wellness center at O'Connell High School
- Student Run Free Clinics – Volunteer FCM and other UCSF faculty preceptors
  - Clínica Martín Baro; UCSF Homeless Clinic; Mabuhay Health Center; SF Hepatitis B Collaborative Mobile Clinic (Vietnamese Community Center)
- Planned Parenthood – Comprehensive reproductive health training for FCM residents (Drs. Dehlendorf, Lee, Pollock)

Research Programs

- Evidence to drive equity
- Person Centered Reproductive Health Program: https://pcrhp.ucsf.edu/ CDehlendorf
- Social Interventions Research and Evaluation Network (SIREN): https://sirenetwork.ucsf.edu/ LGottlieb
- Center for Excellence in Primary Care (CEPC): https://cepc.ucsf.edu RWillard-Grace
- CTSI Community Engagement & Health Policy Program. https://ctsi.ucsf.edu/about-us/programs/community-engagement-health-policy KGrumbach
-

FCM Department Leadership roles

Kirsten Day, MD

Residency Program Director of Diversity, Equity, Inclusion, Justice Advocacy, and Mentorship

Christine Dehlendorf, MD, MAS

Danielle Hessler, PhD

Co-Vice Chairs for Research

Isabel Lee, MD

Vice Chair for Faculty Affairs

Diana Coffa, MD

Margo Vener, MD

Co-Vice Chairs for Education

Academy of Medical Educators Excellence in Teaching Awards

2025

- Chris Bositis, MD
- Megan Mahoney, MD, MBA
- Anthony Mrgudich, MD

2024

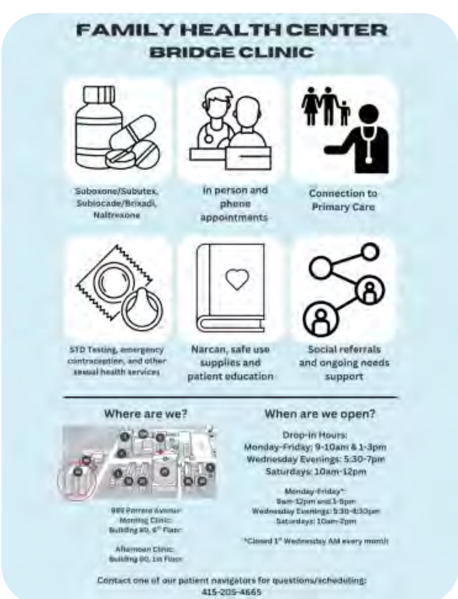
- Mai Fleming, MD
- Sen Nguyen, MD

2023

- Randy Jackson, MD
- Brianna Stein, MD

Honors

Curt Wanda, PA-C
UCSF at ZSFG
Exceptional Advanced Practice Provider Award



FHC Bridge Clinic
UCSF at ZSFG
Interprofessional Collaboration Award

Christine Dehlendorf
National Academy of Medicine

Teresa Villela
UCSF Gold Headed Cane Society

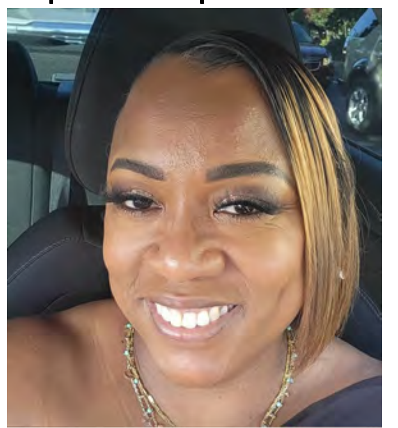
Kevin Grumbach
Holly Smith Award

Department of FCM SHINE Awards

Tami Lenhoff
Inpatient pharmacist

Elizabeth Deely
Residency Prog Coordinator

Karen Huan, RN
Urgent Care Charge Nurse

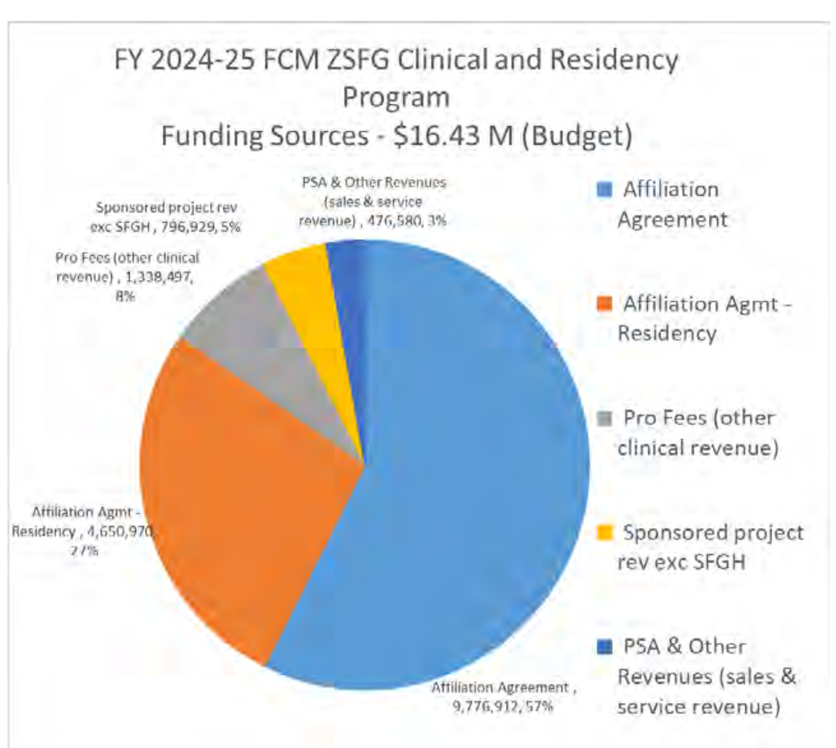


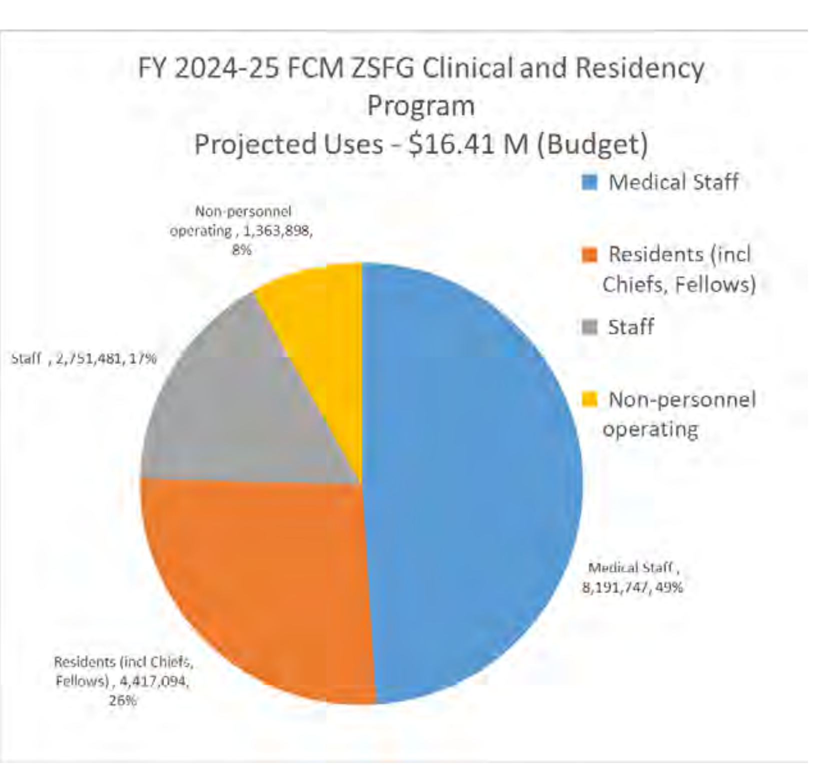
Tamara Thomas
FHC Eligibility Worker

Brenda Goldhammer
Admin Lead, National Consultation Center (NCCC)

Tatyana Durbrosky
FHC Behavioral Assistant

FCM ZSFG Clinical and Residency Program Funding Sources and Uses





Summary

- **Challenges/Opportunities**
  - Family Health Center space – …new space still pending…
  - New leadership: residency program, FHC, UCC
  - Keeping up with demand-driven salaries for primary care physicians
  - Structural challenges: budget, inequities persisting in communities we serve, stressors of immigrant backlash
- **Strengths**
  - Collaborative and talented leadership teams
  - Continuous support from department and associate dean
  - Mission-driven people: staff, faculty members, administrators, residents
  - Patients and families— engaged in more areas of FCM

A Legacy of Strength

- ✓ Mission driven staff, faculty, administrators, residents
- ✓ Family-centered and patient-centered
- ✓ Collaborative and talented leadership teams
- ✓ Supportive department, ZSFG, from UCSF

Comments & Questions

THANK YOU!

City and County of San Francisco

Department of Public Health

Daniel Lurie
Mayor

Zuckerberg San Francisco General Hospital and Trauma Center

Mary Mercer, MD
Chief of Staff

Medical Executive Committee (MEC)
Summary of Changes

Document Name	**ZSFG Clinical Service Rules And Regulations**
Clinical Service:	Family and Community Medicine
Date of last approval:	4/13/2024
Summary of R & R updates:	See below
Update 1:	• Update organization chart • Correct order of attachments • Update privileges document • Update OPPE metrics guide (new format, no substantive changes)

FAMILY & COMMUNITY MEDICINE
CLINICAL SERVICE RULES AND REGULATIONS
2026

FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS

I. FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE ORGANIZATION 4
A. SCOPE OF SERVICE 4
B. MEMBERSHIP REQUIREMENTS 4
C. ORGANIZATION AND STAFFING OF THE FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE 4
II. CREDENTIALING 7
A. NEW APPOINTMENTS 7
B. REAPPOINTMENTS 7
C. AFFILIATED PROFESSIONALS 7
D. STAFF CATEGORIES 7
III. DELINEATION OF PRIVILEGES 7
A. DEVELOPMENT AND ANNUAL REVIEW OF PRIVILEGES 7
B. CLINICAL PRIVILEGES AND MODIFICATION/CHANGE TO PRIVILEGES 7
C. TEMPORARY PRIVILEGES 8
IV. PROCTORING REQUIREMENTS 8
A. PROCTORING AND MONITORING REQUIREMENTS 8
B. PROCTORING AND COMPETENCY REVIEW 9
C. ADDITION OF PRIVILEGES 10
D. REMOVAL OF PRIVILEGES 10
V. EDUCATION 10
VI. FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE RESIDENT TRAINING PROGRAM AND SUPERVISION (Refer to SFHN Website for Housestaff Competencies) 10
A. ROLE, RESPONSIBILITY AND PATIENT CARE ACTIVITIES OF RESIDENTS 10
B. EVALUATION OF RESIDENTS 11
VII. FAMILY AND COMMUNITY MEDICINE CLINICAL SERVICE CONSULTATION CRITERIA 11
VIII. DISCIPLINARY ACTION 11
IX. PERFORMANCE IMPROVEMENT/PATIENT SAFETY (PIPS) AND UTILIZATION MANAGEMENT 11
A. GOALS AND OBJECTIVES 11
B. RESPONSIBILITY 11
C. REPORTING 11
D. CLINICAL INDICATORS 12
E. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES 12
F. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES 12
G. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE 12
X. MEETING REQUIREMENTS 12
XII. ADOPTION AND AMENDMENT 12

FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS (Continued)

APPENDICES

APPENDIX A - FAMILY & COMMUNITY MEDICINE AT ZSFG ORGANIZATIONAL STRUCTURE 13

APPENDIX B - CHIEF OF FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE JOB DESCRIPTION 14

APPENDIX C - FHC CLINICAL RESEARCH POLICY 17

APPENDIX D - ATTENDING PHYSICIAN RESPONSIBILITIES IN THE FAMILY HEALTH CENTER 18

APPENDIX E - FAMILY & COMMUNITY MEDICINE PRIVILEGES 20

APPENDIX F - CHART REVIEW FORMS 28

APPENDIX G - OPPE FORM AND THRESHOLDS 31

I. FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The Family and Community Medicine Clinical Service (FCM) at Zuckerberg San Francisco General (ZSFG) is responsible for: ambulatory patient care delivered in the ZSFG Family Health Center and ZSFG Urgent Care Center; medical services provided in the ZSFG Skilled Nursing Facility and the Behavioral Health Center; inpatient care delivered on the ZSFG Family Medicine Inpatient Service; and inpatient obstetrical care provided through the Prenatal Partnership Program of the Family and Community Medicine Service. The Department of Family and Community Medicine sponsors the UCSF Family and Community Medicine Residency Program, based at ZSFG.

B. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of Zuckerberg San Francisco General Hospital is a privilege which shall be extended to those practitioners who are professionally competent and continually meet the qualifications, standards, and requirements set forth in ZSFG Medical Staff Bylaws, Rules, Regulations, and these Clinical Service Rules and Regulations.

Initial appointment will be made based on demonstrated competence in the candidate's previous training and practice. Certification or eligibility for certification by the American Board of Family Medicine (or its equivalent for individuals in specialties other than Family Medicine) is required.

C. ORGANIZATION AND STAFFING OF THE FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE

1. Organization

The Family and Community Medicine Clinical Service structure is presented on the attached organization chart (**Appendix A**). The officers of the FCM Clinical Service are the Chief of Service and the Vice-Chief of Service.

a) Chief of Service

The Chief of Service is appointed through the mechanism described in the ZSFG Medical Staff Bylaws with concurrence at the hospital level, by the Director of Public Health, and by the Chairman of the Department of Family and Community Medicine at the University of California in San Francisco. The Chief of Service fulfills the range of duties described in the ZSFG Medical Staff Bylaws. The job description for the Chief of Service is detailed in **Appendix B**.

b) Vice Chief of Service

The Vice Chief of Service is appointed by the Chief of Service, serves for an indefinite term, and serves as acting Chief of Service when the Chief of Service is unavailable.

c) Directors, Family Health Center (FHC)
The directors provide leadership and oversight of the FHC and overall direction of clinical and research activities in the FHC (see **Appendix C** for the FHC Clinical Research Policy). The directors shall develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary; coordinate the FHC's participation in the Performance Improvement and Patient Safety Program relating to the FHC; and prepare budgets and other reports in collaboration with the Nurse Manager, MSO, and/or Chief of Service.

d) Directors, Family Medicine Inpatient Service (FMIS)
The directors provide leadership and oversight of the FMIS and overall direction of the service, including clinical operations and educational activities. The directors shall develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary, and coordinate FMIS participation in the Performance Improvement and Patient Safety Program.

e) Directors, Prenatal Partnership Program (PPP)
Directors provide leadership and oversight of the PPP and overall direction of the PPP, including clinical operations and educational activities. The directors shall develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary, and coordinate the PPP's participation in the Performance Improvement and Patient Safety Program.

f) Director, Skilled Nursing Facility (SNF)
The director provides leadership and oversight of the SNF and overall direction of the SNF, including clinical operations and educational activities. The director shall develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary, and coordinate the SNF's participation in the Performance Improvement and Patient Safety Program.

2. Clinical Services

a. Family Health Center
The FHC is an ambulatory care setting located on the ZSFG campus on the first and fifth floors of Building 80 and first floor of Building 90. FHC care is delivered using a Family Medicine model. Care is provided with concern for the total health care of the individual and the family, and the scope of practice is not limited by age, sex, organ system, or disease entity. Biological, clinical, and behavioral sciences are integrated in the care provided by family physicians, family nurse practitioners, and physician assistants at the FHC. Hours of operation are 8:30 a.m. to 9:00 p.m. Monday through Thursday, 8:30 a.m. to 5:00 p.m. Friday, and 8:30 a.m. to 12:00 noon on Saturday.

Comprehensive continuity care is provided with particular emphasis placed on preventive care and health maintenance. All FHC patients have an assigned primary care provider who sees them for the majority of their visits.

Urgent care for FHC patients is available on site on a drop-in basis or by appointment during the hours of operation. After-hours telephone advice is provided by a nurse advice line in collaboration with family medicine faculty members. Patients are encouraged to call for telephone advice during off hours and may be referred for evaluation at the FHC, at the ZSFG Emergency Department, Urgent Care Center, or Pediatric Urgent Care Center as appropriate.

b. ZSFG Family Medicine Inpatient Service

The FM Inpatient Service is a non-geographic adult medical service which provides acute inpatient care to FHC patients and patients enrolled in designated San Francisco Health Network clinics. The FM Inpatient Service emphasizes ongoing communication with primary care clinicians during inpatient episodes of care for patients receiving continuity of care from these clinicians. The service is staffed by UCSF FCM residents and family medicine attending physicians.

c. ZSFG Skilled Nursing Facility

The SNF is an interdisciplinary unit with medical services provided under the supervision of the SNF Medical Director, a member of the Family and Community Medicine Service. Medical care is provided by the SNF Medical Director, FCM attending physicians, and nurse practitioners, in accordance with existing policies for the SNF.

d. ZSFG Urgent Care Center

The UCC provides urgent care for patients whose primary care home is in the San Francisco Health Network, as well as patients without a primary care provider. The UCC Medical Director is a member of the Family and Community Medicine Service. UCC care is provided by physicians, nurse practitioners, and physician assistants.

e. Prenatal Partnership Program

The Prenatal Partnership Program is administered through Family and Community Medicine to provide family-centered birth services at ZSFG. Birthing services are provided by FCM physician attendings and residents and by attendings in the ZSFG Community Primary Care Service. Family physician attendings in the Community Primary Care Services who participate in the Prenatal Partnership Program receive their privileges for inpatient obstetrical care through the Family and Community Medicine Service.

f. Attending Physician Responsibilities

Overall direction of clinical care is the responsibility of the FCM attending staff either directly or through supervision of residents, affiliated medical staff members, and medical students. Requirements for FCM attending physicians are detailed in **Appendix D**.

II. CREDENTIALING

A. NEW APPOINTMENTS

The process of application for membership to the ZSFG Medical Staff through FCM is in accordance with ZSFG Bylaws, Rules, and Regulations, as well as with these Clinical Service Rules and Regulations.

B. REAPPOINTMENTS

The process of reappointment to the ZSFG Medical Staff through FCM is in accordance with ZSFG Bylaws, Rules, and Regulations, as well as with these Clinical Service Rules and Regulations.

1) Modification of Clinical Service
The process for modification of FCM clinical services will be through the appropriate required review process.

2) Staff Status Change
The process for Staff Status Change for FCM members is in accordance with ZSFG Bylaws, Rules, and Regulations.

3) Modification/Changes to Privileges
The process for modification or change to privileges for FCM members is in accordance with ZSFG Bylaws, Rules, and Regulations.

C. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of affiliated professionals to the ZSFG Medical Staff through FCM is in accordance with ZSFG Bylaws, Rules, and Regulations, as well as with these Clinical Service Rules and Regulations.

D. STAFF CATEGORIES

FCM staff members fall into the same categories described in the ZSFG Bylaws and Rules and Regulations, as well as in these Clinical Service Rules and Regulations.

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT AND ANNUAL REVIEW OF PRIVILEGES

FCM privileges are developed in accordance with ZSFG Medical Staff Bylaws, Rules, and Regulations, as well as with these Clinical Service Rules and Regulations.
The FCM Privilege Request Form shall be reviewed annually by the Chief of Service.

B. CLINICAL PRIVILEGES AND MODIFICATION/CHANGE TO PRIVILEGES

(Refer to **Appendix E**)

1. FCM clinical privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Rules, and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of Service.

2. The process for modification or change to privileges of FCM members is in accordance with the ZSFG Medical Staff Bylaws, Rules, and Regulation.

3. FCM grants privileges to clinicians working in the ZSFG FHC, UCC, FMIS, SNF, BHC, and Birth Center.

a) Request for clinical privileges will be evaluated by the Chief of Service. The initial determination of such requests shall be based on the applicant's education, training, experience, and demonstrated competence. The applicant shall have the burden of establishing his/her qualifications and competency for the clinical privileges requested.

b) FCM privileges permit practice within the ZSFG FHC, UCC, FMIS, SNF, BHC, Birth Center, and in related sites (e.g., patients' homes).

c) Evidence must be presented of having training and successful experience for each privilege requested.

C. TEMPORARY PRIVILEGES

Temporary privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Rules, and Regulations.

IV. PROCTORING AND MONITORING

A. PROCTORING AND MONITORING REQUIREMENTS

FCM proctoring and monitoring requirements shall be the responsibility of the Chief of Service, with the primary review delegated to the medical directors of the FHC, FMIS, UCC, SNF, and PPP.

The scope of individual provider activity is determined by level of training and skills obtained in special procedure training. Clinical competence is monitored through direct

observation, chart review, and practice audits. In general, the scope of provider activity is in keeping with that defined by the American Board of Family Medicine and the Accreditation Council of Graduate Medical Education (ACGME) Residency Review Committee for Family Medicine. All care delivered by non-licensed residents is directly supervised by an attending physician in both the inpatient and outpatient settings. Licensed residents may be indirectly supervised only after meeting criteria outlined by the FCM Residency Program Clinical Competence Committee. The FM Inpatient Service physician of record is always a family physician faculty member.

B. PROCTORING AND COMPETENCY REVIEW

1. INITIAL APPOINTMENT

Initial appointment will include review of qualifications, prerequisites, and previous experience for each privilege requested. The privileges request form (**Appendix E**) specifies the qualifications, prerequisites, and proctoring requirements for each privilege. Proctoring for initial appointment will include direct observation, case review, and review of the medical record. Forms used for documentation of case reviews are included in **Appendix F**.

The Medical Directors perform or assign proctoring. In instances when these individuals are the candidates to be proctored, the Chief of Service or designee will be assigned as proctor. The Chief of Service will be reviewed by the vice Chief of Service.

If the minimum number of proctored cases is insufficient for making a valid determination of clinical competence, proctoring will continue until a valid determination of clinical competence is achieved. This determination will be made jointly by the proctor and the Chief of Service.

A summary proctoring report will be sent to the Chief of Service for review and approval.

2. REAPPOINTMENT

a. Following initial appointment, review will be performed prior to each reappointment. The Chief of Service will be responsible for this evaluation. The evaluation will be based on a combination of concurrent assessment by the medical directors and clinical data sources for ambulatory and inpatient care.

b. Clinical performance data for review will consist of the following.

- **i.** Chart review: A minimum number of cases and charts will be reviewed for each privilege for which the clinician is credentialed, as outlined in the FCM privileges form (**Appendix F**).
- **ii.** Clinical indicators and practice profiles: These indicators will be reviewed for the entire population of patients for whom the

clinician had primary clinical responsibility during the two-year period preceding reappointment. These will be reported to the provider and the ZSFG Medical Staff Office every 11 months as an Ongoing Professional Practice Evaluation (OPPE).

iii. Case presentation: At least once during the reappointment period, each physician will present, to the FCM faculty, a patient case or cases for which he/she is clinically responsible.

iv: Other information as appropriate, including unusual incidence reports, adverse drug reaction reports, and similar information collected by ZSFG committees.

c. The Chief of Service will be reviewed by the Vice Chief of Service.

C. ADDITION OF PRIVILEGES

Requests for additional FCM privileges shall be in accordance with ZSFG Bylaws, Rules, and Regulations.

D. REMOVAL OF PRIVILEGES

Requests for removal of FCM privileges shall be in accordance with ZSFG Bylaws, Rules, and Regulations.

V. EDUCATION

The following FCM educational opportunities are regularly offered:

- Department of Family and Community Medicine Grand Rounds, monthly
- FCM Clinical Staff Meetings, monthly
- Morbidity and Mortality Conference, monthly
- Case conferences at attending faculty meetings, monthly
- Faculty Development Sessions, minimum three per year
- Other FCM-sponsored seminars and conferences

VI. FAMILY & COMMUNITY MEDICINE RESIDENT TRAINING PROGRAM AND SUPERVISION (Refer to SFHN Website for House staff Competencies)

Attending faculty shall supervise residents in such a way that house staff assumes progressively increasing responsibility for patient care according to level of training, ability, and experience.

A. ROLE, RESPONSIBILITY, AND PATIENT CARE ACTIVITIES OF RESIDENTS

Residents are trained in accordance with ACGME, American Board of Family Medicine, UCSF, ZSFG, and California Medical Board guidelines.

B. EVALUATION OF RESIDENTS

Residents are evaluated in accordance with ACGME guidelines for both inpatient and outpatient care. The evaluation process consists of written rotation evaluations, written outpatient evaluations, and written evaluations of required didactic presentations. The FCM Residency Program Clinical Competence Committee reviews evaluations for each resident twice yearly and advises the Residency Program Director through a summary evaluation and promotion recommendations.

VII. FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE CONSULTATION CRITERIA

Consultation in all categories of privileges will be expected for patients whose condition is critical, deteriorating, unresponsive to the therapy initiated, or when diagnostic problems remain unresolved.

VIII. DISCIPLINARY ACTION

The ZSFG Bylaws, Rules, and Regulations will govern all disciplinary action involving FCM members.

IX. PERFORMANCE IMPROVEMENT/PATIENT SAFETY AND UTILIZATION MANAGEMENT

A. GOALS AND OBJECTIVES

The Chief of Service, or designee, is responsible for evaluation and improvement of clinical performance, for ensuring patient safety, and for identifying and implementing solutions to quality-of-care issues. As necessary, assistance is invited from other departments, the Performance Improvement/Patient Safety Committee, or the appropriate administrative committee or organization.

B. RESPONSIBILITY

Overall responsibility for performance improvement lies with the Chief of Service. A Director of Quality Improvement is appointed by the Chief of Service to supervise and coordinate performance improvement activities and to serve as the FCM representative to the ZSFG Performance Improvement and Patient Safety Committee. In collaboration with the FCM Director of Quality Improvement, medical directors of FCM clinical programs will be responsible for collecting and reviewing performance improvement indicator data and reviewing any adverse events. At least eight times per year, the FCM clinical staff will meet to discuss, review, and plan performance improvement activities.

C. REPORTING

Performance Improvement and Patient Safety (PIPS) and Utilization Management (UM) activity records will be maintained by FCM. Minutes are available for review of ZSFG Medical Staff Services.

D. CLINICAL INDICATORS

In collaboration with the ZSFG PIPS Department, a calendar of review of clinical indicators of patients is established for each year. The PIPS Department monitors these throughout the year through data, chart, and patient panel reviews. This information, along with the information gathered from the PIPS Department is compiled and presented to the ZSFG PIPS committee.

E. CLINICAL SERVICE ONGOING PROFESSIONAL PRACTICE EVALUATIONS

In collaboration with the ZSFG Performance Improvement and Patient Safety Department, FCM selects clinical indicators to monitor the performance of each physician with primary direct clinical responsibility for a population of patients. These Ongoing Professional Practice Evaluations (OPPEs; see **Appendix G**) are produced, reviewed, and disseminated to each provider by the Chief of Service. OPPEs for all physicians are compiled and presented to the ZSFG Medical Staff Office every eleven months.

F. MONITORING AND EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

FCM monitors and evaluates each practitioner for appropriateness of patient care, and the Chief of Service maintains these records.

G. MONITORING AND EVALUATION OF PROFESSIONAL PERFORMANCE

FCM monitors and evaluates each practitioner, and the Chief of Service maintains these records. OPPE clinical indicators and thresholds are detailed in **Appendix G**.

X. MEETING REQUIREMENTS

In accordance with ZSFG Bylaws, all active members are expected to show good-faith participation in the governance and quality evaluation process by attending a minimum of 50% of all committee meetings assigned, clinical service meetings, and the annual Medical Staff Meeting.

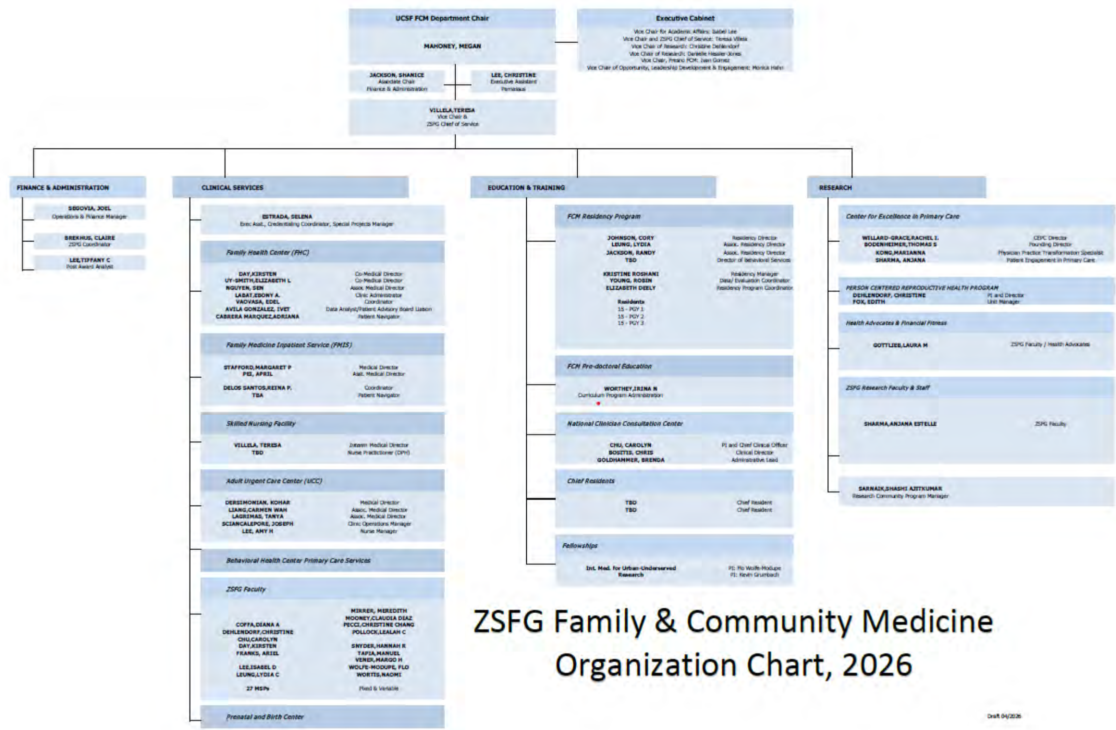
FCM members shall meet as frequently as necessary, but at least quarterly, to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

As defined in the ZSFG Bylaws, a quorum is constituted by at least three (3) voting members of the active staff for the purpose of conducting business.

XI. ADOPTION AND AMENDMENT

The FCM Rules and Regulations will be adopted and revised annually by a majority vote of all active service members.

APPENDIX A: FAMILY & COMMUNITY MEDICINE ORGANIZATIONAL STRUCTURE



APPENDIX B: JOB DESCRIPTION, CHIEF OF ZSFG FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE

Chief, Family and Community Medicine Service

Zuckerberg San Francisco General Hospital

The primary responsibility of the Chief of the ZSFG Family and Community Medicine Service (FCM) is to assure the integrity and quality of the clinical services administered by the UCSF Department of Family and Community Medicine at Zuckerberg San Francisco General Hospital (ZSFG). The Chief of Service has direct accountability to the Chief of the ZSFG Medical Staff and the UCSF Associate Dean at ZSFG, in addition to the Chair of the UCSF Department of Family and Community Medicine and the ZSFG Executive Administrator. The Medical Directors of FCM-administered clinical services at ZSFG report to the FCM Chief of Service. The Chief of Service works in close collaboration with the other ZSFG chiefs of service and ZSFG nursing and administrative leaders to promote the collective excellence and accountability of ZSFG services and programs.

The Chief of Service, in consultation with the Chair of the UCSF Department of Family and Community Medicine, has responsibility for recruiting and supervising faculty members of the department who are based at ZSFG. With the support of the department's manager at ZSFG, the Chief of Service is responsible for managing the department's funds related to ZSFG professional fee income, the Affiliation Agreement between UCSF and the City and County of San Francisco, other funds involving ZSFG clinical operations, and such other funds as the Chair of 77the Department delegates to be principally managed by the Chief of Service.

The Chief of Service works closely with the Director of the UCSF-ZSFG Family and Community Medicine Residency Program to assure the integrity of the residency training program and the integration of the training program into the clinical services at ZSFG, including assuring compliance with hospital rules and regulations, ACGME standards, and related policies and regulations. The Chief of Service also works closely with the department's Director of Predoctoral Education to assure successful operation of FCM medical student teaching programs at ZSFG and works with educational leaders of the other UCSF health professional schools on issues relating to students' educational experiences on FCM clinical services.

The Chief of Service works in collaboration with the Chair of the UCSF Department of Family and Community Medicine to enhance the academic environment for the department's programs based at ZSFG, including research and community service.

The Chief of Service is expected to serve as an attending physician on the ZSFG Medical Staff and perform direct patient care as part of the FCM Service. At a minimum, the Chief of Service is expected to have a continuity family medicine practice and supervise residents and medical students at the Family Health Center. Ideally, the Chief of Service will serve as an attending physician on the Family Medicine Inpatient Service and/or Perinatal Partnership Program family medicine obstetrical call group.

As a member of the UCSF faculty, the Chief of Service is expected to be involved in scholarly activities and contribute to the generation and translation of knowledge in areas of inquiry relevant to family medicine. The extent of involvement in research and scholarly activities will be based on the interests and qualifications of the Chief of Service.

The UCSF-City and County of San Francisco Affiliation Agreement and ZSFG Medical Staff Bylaws fully delineate the responsibilities of chiefs of service, including the following:

A. ADMINISTRATION

1. General Responsibilities

a) Be responsible and accountable to the governing body through the Medical Executive Committee (MEC) for the clinical and administratively related activities within the clinical service;

b) Be a participating member of the MEC;

c) Be responsible for the integration of the clinical service into the primary functions of the organization;

d) Be responsible for the coordination and integration of inter- and intra-departmental services;

e) Provide administrative leadership for a culturally sensitive and competent program to the community served by ZSFG; and

f) Provide administrative leadership for a culturally sensitive environment for UCSF and ZSFG employees and trainees.

2. Planning

a) Provide direction and participate in the planning, implementation and evaluation of the organization's plan for patient care;

b) Assess the effect of UCSF academic and program planning upon ZSFG and directly communicate this information as part of the joint UCSF/ZSFG program planning;

c) Stay abreast of changes in the health care industry, both locally as well as industry-wide, and demonstrate leadership by identifying and implementing appropriate changes; and

d) Assist in the preparation of annual reports, including budgetary planning, pertaining to the clinical service as may be required by the Chief of Staff, the MEC, the Associate Dean, Executive Administrator, or the Governing Body.

3. Resource Management

Manage City and University resources, including revenue and expenses, appropriately and in a timely manner, as evidenced by:

a) Appropriate budget preparation and monitoring based on service goals;

b) Maximizing reimbursement and other revenues;

c) Ensuring compliance with third party billing regulations, including timely and appropriate documentation in the medical record;

d) Ensuring effective utilization of assigned clinical, administrative and research space;

e) Adhering to UCSF and ZSFG financial policies; and

f) Reporting and recommending to hospital management, when necessary, with respect to matters affecting patient care in the clinical service, including personnel, space and other resources, supplies, special regulations, standing orders and techniques;

4. Operations Management

a) Designate an acting chief when the Chief of Service will be absent for a period longer than 24 hours but less than 30 days. After thirty (30) days, the process described in the Medical Staff Bylaws will be followed;

b) Assume responsibility for orienting new members and enforce the Medical Staff Bylaws, Rules, Regulations, and Policies, the clinical service rules and regulations, and the hospital's policies and procedures within the respective clinical service;

c) Participate in the administration of the Clinic Service through cooperation with the Nursing Service, Hospital Administration and all personnel involved in matters affecting patient care.

B. COMMUNICATION

1. Communicate appropriately with hospital administration, the ZSFG Dean's Office and Department faculty and staff;
2. Communicate information to faculty, residents, and students;
3. Promote effective communication and collaboration among health care professionals; and
4. Develop and maintain appropriate relationships within the San Francisco community.

C. PERFORMANCE IMPROVEMENT

1. Monitor and evaluate the quality and appropriateness of patient care provided within the clinical service, utilizing a quality improvement program that measures patient care outcomes;
2. Monitor the professional performance of all individuals who have clinical privileges in the clinical service, and report thereon to the Credentials Committee as part of the Reappointment process and at such other times as may be indicated;
3. Appoint ad hoc committees or working groups, as necessary, to carry out quality improvement activities;
4. Demonstrate the ability to assess issues and effectively solve problems; and
5. Implement and monitor agreed-upon standards for program operations; address performance problems effectively and in a timely manner.

D. MEDICAL STAFF CREDENTIALING AND PRIVILEGING

1. Recommend criteria for clinical privileges in the clinical service;
2. Recommend sufficient number of qualified and competent individuals to provide care/clinical services;
3. Make a report to the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for all applicants seeking privileges in the clinical service;
4. Make recommendations to the Credentials Committee regarding the qualifications and competence of clinical service personnel who are affiliated professional staff; and
5. Assume responsibility for the evaluation of all provisional appointees and report thereon to the Credentials Committee.

E. EDUCATION AND RESEARCH

1. Be accountable to the Associate Dean and the UCSF Department Chair for the conduct of graduate and undergraduate medical education and UCSF-based research programs conducted in the FCM Clinical Service;
2. Assume responsibility for the establishment, implementation and effectiveness of the orientation, teaching, education and research programs in the Clinical Service; and
3. Ensure the quality of resident teaching by monitoring outcomes.

Updated 2020

APPENDIX C: FHC CLINICAL RESEARCH POLICY

Zuckerberg San Francisco General Hospital
Family Health Center
Date Adopted: 5/02
Reviewed: 6/04, 05/16
Revised: 9/05, 05/16

TITLE: *Criteria for Approval of Research Studies at the Family Health Center*

STATEMENT OF POLICY**: It is the policy of the Family Health Center to require researchers conducting studies which involve FHC patients to meet clear hospital and clinic guideline.**

POLICY: For research to be conducted at the FHC the following requirements must be met:

1. Minimal additional administrative work for FHC staff or providers.
2. No obvious duplication of patient contacts by concurrent research studies.
3. Letters to patients are not signed by FHC staff or providers. There is no implication of FHC provider involvement, unless appropriate.
4. Providers are given patient lists for review prior to patient contact.
5. Study is relevant to our patients, and appropriate patient incentives are included.
6. Research group will present outcome of study for FPRP/FHC during noon conference or All Team Meeting.
7. Study must be approved by the appropriate IRB/CHR.
8. The FHC requests that all studies involving FHC patients make a voluntary donation to the clinic. The suggested donation range is $50-$500, depending on the total study budget. If this would represent a hardship, please let us know and we can discuss your circumstances. These funds are used to support FHC staff development and team-building activities.

Researchers will follow these steps:

1. Initial contact by research study group to Medical Director.
2. Letter sent to research group which outlines FHC criteria for approval of research studies.
3. If study group believes they do or can meet all criteria, protocol is sent to FHC Medical Director.
4. Protocol is reviewed by Management Team with consultation by Teresa Villela, Chief of Service.
5. Research study group gives lists of potential patient contacts to primary care providers for review.
6. Final list of contacts is given to Medical Director.
7. Study proceeds.

Approved by:

Lydia Leung, M.D.
Medical Director, Family Health Center

APPENDIX D: ATTENDING PHYSICIAN RESPONSIBILITIES FAMILY HEALTH CENTER

Update Table...

Contents

Quick Links & Important Documents 2
Expectations 3
Points of Contact 3
Clinical Support 3
Residency Support 4
Administrative Support 4
Schedules 5
Sick calls or emergency situations for **PCPs** 5
Sick calls or emergency situations for **Preceptors** 5
Precepting Session (Overview) 6
Before/Start of precepting session 6
During each clinic session, your primary responsibilities 7
If there are active issues (patients sick or further evaluation needed) beyond 12pm 7
If there are active issues (patients sick or further evaluation needed) beyond 5pm 8
If patients need direct admission to SFGH 8
If patients need to be transferred to ED for higher level of care and evaluation 8
If you have any urgent clinical or non-clinical questions or issues that you do not feel comfortable with, please contact: 8
Evaluations of learners 9
For all learners 9
For residents 9
Precepting Residents 9
Before you precept 9
Precepting documentation guidelines 9
Working with Clinician of the Day (COD) 11
Resident Backup 11
81 Attending Responsibilities 11
FHC Same-Day Drop-in clinic 11
Your role as attending for Drop-in clinic 11
Rx Requests / Prescription Refills: 12
Help check resident InBaskets: 12
Best Practices for 81 attending: 13
85/91 Attending Responsibilities 13

1

APPENDIX E: FAMILY & COMMUNITY MEDICINE PRIVILEGES

JCC: 02/2025

FOR ALL PRIVILEGES
All complication rates, including problem transfusions, deaths, unusual occurrence reports and sentinel events, as well as Department quality indicators, will be monitored semiannually.

14.00 OUTPATIENT CLINIC PRIVILEGES ___

14.01 AMBULATORY CARE PRIVILEGES FOR FAMILY MEDICINE PREPARED PHYSICIANS ___
Perform basic procedures within the usual and customary scope of Family Medicine; diagnosis, management, treatment, preventive care, and minor procedures for patients of all ages in the Family Health Center (FHC), FHC satellites, or the patient's home. All procedures requiring anesthesia to be performed under local anesthesia. May refer patients for admission to the appropriate Inpatient Service, and may write informational notes in the SFGH inpatient medical record.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.02 AMBULATORY CARE PRIVILEGES FOR INTERNAL MEDICINE OR EMERGENCY MEDICINE PREPARED PHYSICIANS ___
Perform basic procedures within the usual and customary scope of Internal Medicine or Emergency Medicine; diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the Family Health Center (FHC), FHC satellites, or the patient's home. All procedures requiring anesthesia to be performed under local anesthesia. May refer patients for admission to the appropriate Inpatient Service and may write informational notes in the SFGH inpatient medical record.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Internal Medicine, the American Board of Emergency Medicine.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.03 BEHAVIORAL HEALTH CENTER PRIVILEGES ___
Performs basic procedures within the usual and customary scope of Family Medicine or Internal Medicine; diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the Behavioral Health Center.

Concurrence of Behavioral Health Center Medical Director required:

_______________________________________ ____________________
Signature, Behavioral Health Ctr Medical Director Date

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-certified by the American Board of Family Medicine, or the American Board of Internal Medicine.

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 3 cases

14.10 INPATIENT CARE PRIVILEGES ___
Admit and be responsible for hospitalized adults. Admissions may include medical, surgical, gynecological, and neurological problems, and medical complications in pregnant patients with obstetric consultation. May also follow patients admitted to critical care units in a consultative capacity.

14.11 FAMILY MEDICINE INPATIENT SERVICE PRIVILEGES ___
Perform basic procedures within the usual and customary scope of Family Medicine; diagnosis, management, treatment, preventive care, and minor procedures for hospitalized adults.

<u>PREREQUISITES:</u> Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

<u>PROCTORING:</u> Review of 5 cases.

<u>REAPPOINTMENT:</u> Review of 3 cases.

14.12 SKILLED NURSING FACILITY CARE PRIVILEGES ___
Perform basic procedures within the usual and customary scope of Family Medicine or Internal Medicine; diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the SFGH Skilled Nursing Facility (SNF).

Concurrence of Skilled Nursing Facility Medical required:

____ ____________________
Signature, Skilled Nursing Facility Medical Director Date

<u>PREREQUISITES:</u> Currently Board Admissible, Board Certified, or Re-Certified byt the American Board of Family Medicine, the American Board of Internal Medicine.

<u>PROCTORING:</u> Review of 5 cases.

<u>REAPPOINTMENT:</u> Review of 3 cases.

14.13 NURSERY PRIVILEGES ___
Render care to well newborns, including admitting and performing routine evaluations and management.

<u>PREREQUISITES:</u> Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

<u>PROCTORING:</u> Case review for 3 newborn admissions

<u>REAPPOINTMENT:</u> Case review of 2 newborn admissions

<u>14.20 PERINATAL PRIVILEGES</u> ___
Render care to women during the perinatal period, including specific privileges 14.21 through 14.27, if requested and approved below:

14.21 NORMAL VAGINAL DELIVERY ___
Including administration of local anesthesia, performance of episiotomy, and repair of lacerations other than those involving the rectal sphincter.

<u>PREREQUISITES:</u> Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

<u>PROCTORING:</u> Case review and direct observation of a minimum of 3 deliveries.

<u>REAPPOINTMENT:</u> Review of 3 cases.

14.22 VACUUM ASSISTED DELIVERIES (OB CONSULTATION REQUIRED) ___

Concurrence of the Chief of OB/Gyn required:

____ ____________________
Signature, chief of OB/GYN Date

<u>PREREQUISITES:</u> Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

<u>PROCTORING:</u> For applicants with documentation of prior successful performance of a minimum of 25 vacuum assisted deliveries: case review and direct observation of a minimum of 2 deliveries using vacuum assistance. For applicants with documentation of fewer than 25 vacuum assisted deliveries: case review and direct observation of 5 deliveries using vacuum assistance.

<u>REAPPOINTMENT:</u> Case review of 1 delivery using vacuum assistance.

14.23 FIRST ASSIST IN CESAREAN DELIVERY (OBSTETRICS CONSULTATION REQUIRED) ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine and documentation of prior successful performance of a minimum of 25 Cesarean deliveries.

PROCTORING: Case review and direct observation of 5 Cesarean deliveries.

REAPPOINTMENT: Case review of 1 Cesarean delivery.

Concurrence of the Chief of OB/Gyn required:

____ ____________________
Signature, Chief of OB/GYN Date

14.24 ULTRASOUND IN PREGNANCY ___

Limited to determination of fetal gestational age, confirmation of presentation, placenta location, amniotic fluid adequacy, and confirmation of fetal heart rate.

a. Basic First and Second Trimester Ultrasound (for dating, viability and location of pregnancy) ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine and documentation of a minimum of 8 hours instruction and didactic training in ultrasound technology and imaging.

PROCTORING: For providers with documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution (residency or medical staff): case review and direct observation of 5 dating ultrasounds.For providers without documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution: 8 hour obstetric ultrasound course followed by direct observation of 10 dating ultrasounds and a further retrospective review of an additional 10 dating ultrasound cases/images.

REAPPOINTMENT: Retrospective review of four (4) cases/images in the past 2 years.

b. Limited Third Trimester Ultrasound (assessment of viability, fetal position, placental location, single deepest pocket of amniotic fluid) ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine and documentation of a minimum of 8 hours instruction and didactic training in ultrasound technology and imaging.

PROCTORING: For providers with documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution (residency or medical staff): case review and direct observation of 5 limited third trimester ultrasounds.
For providers without documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution: 4 hour obstetric ultrasound course followed by case review and direct observation of 5 limited third trimester ultrasounds.

REAPPOINTMENT: Retrospective review of two (2) cases/images in the past 2 years.

14.25 External Cephalic Version ___

PREREQUISITES: Currently admissible, certified, or recertified by the American Board of Family Medicine; active FCM Cesarean delivery privileges; and documentation of a minimum of 2 procedures.

PROCTORING: Concurrent review of 2 cases.

REAPPOINTMENT: Case reviews done in accordance with Obstetrics and Gynecology department quality improvement process.

14.26 CESAREAN DELIVERY ___

PREREQUISITES: Currently admissible, certified, or recertified by the American Board of Family Medicine; completion of 12-month fellowship including training in operative obstetrics; and documentation of a minimum of 50 Cesarean deliveries or active Cesarean delivery privileges within the last 5 years.

PROCTORING: Concurrent review of 5 Cesarean deliveries.

REAPPOINTMENT: Satisfactory performance of a minimum of 10 Cesarean deliveries in 2 years. Case reviews done in accordance with Obstetrics and Gynecology department quality improvement process.

Concurrence of the Obstetrics and Gynecology Service Chief required.

____
Signature, Obstetrics and Gynecology Service Chief

14.27 POSTPARTUM STERILIZATION ___

Prerequisites: Currently admissible, certified, or recertified by the American Board of Family Medicine; and documentation of a minimum of 10 procedures within the last 2 years.

Proctoring: Concurrent review of 2 cases.

Reappointment: Case reviews done in accordance with Obstetrics and Gynecology department quality improvement process.

14.30 SPECIAL PRIVILEGES ___

Physicians may apply for each of the following procedural privileges separately based on qualifications and scope of practice.

14.31 LUMBAR PUNCTURE ___

PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).

PROCTORING: Review of 2 cases, one of which may be performed on a simulated model.

REAPPOINTMENT: Review of 2 cases, one of which may be performed on a simulated model.

14.32 PARACENTESIS ___

PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).

PROCTORING: Review of 2 cases, one of which may be performed on a simulated model.

REAPPOINTMENT: Review of 2 cases, one of which may be performed on a simulated model.

14.33 THORACENTESIS ___

PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).

PROCTORING: Review of 2 cases, one of which may be performed on a simulated model.

REAPPOINTMENT: Review of 2 cases, one of which may be performed on a simulated model.

14.34 PLACEMENT OF CENTRAL VENOUS CATHETER, INCLUDING FEMORAL VENOUS CATHETER ___

PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).

PROCTORING: Review of 2 cases, one of which may be performed on a simulated model.

REAPPOINTMENT: Review of 2 cases, one of which may be performed on a simulated model.

14.35a ENDOMETRIAL BIOPSY ___

PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Perinatal Privileges (14.20).

PROCTORING: Review of 2 cases.

REAPPOINTMENT: Review of 2 cases.

___
___
14.35b INTRAUTERINE DEVICE (IUD) INSERTION ___

PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Perinatal Privileges (14.20).

PROCTORING: Review of 2 cases.

REAPPOINTMENT: Review of 2 cases.

14.36 SURGICAL TERMINATION OF FIRST TRIMESTER INTRAUTERINE PREGNANCY
Perform surgical abortions in the first trimester of pregnancy at appropriate facilities at SFGH.

PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the American Board of Family Medicine. Completion of at least 20 hours of formal training in surgical abortion, including first trimester ultrasound for confirmation of intrauterine pregnancy and determination of gestational age, during residency or a CME program, and documentation of 50 procedures.

PROCTORING: Case review of 3 surgical terminations.

REAPPOINTMENT: Case review of 2 terminations.

14.37 VASECTOMY ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine. Completion, as a licensed physician, of a minimum of 20 vasectomy procedures under supervision of a privileged and Board Certified Urologist or Family Physician.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.38 CIRCUMCISION ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics or American Board of Family Medicine. Documentation of proficiency from a Residency program with at least 5 cases, OR, documentation of previous privileges at another hospital with at least 5 cases, OR, minimum of 5 cases performed with assistance from a supervising attending with circumcision privileges, until provider and supervisor determine the provider can perform under proctoring.

PROCTORING: Direct observation of 3 independently performed cases (consecutive/concurrent).

REAPPOINTMENT: Review of 3 cases.

14.40 LIMITED AMBULATORY CARE PRIVILEGES ___

14.41 ACUPUNCTURE ___
Perform acupuncture, acupressure, and moxibustion in the Family Medicine Inpatient Service, Family Health Center (FHC), Skilled Nursing Facility, FHC Satellites and in the patient's home.

PREREQUISITES: Successful completion, by a licensed physician of at least 200-hours instruction and didactic training course given by a UC or other nationally recognized university.

PROCTORING: 5 direct observations and 5 cases to be reviewed by a medical staff member who maintains unproctored status for Acupuncture Privileges within the CHN/SFGH system. Direct observations and chart reviews may be on the same patient or on different patients. A summary monitoring report will be sent to the respective Clinical Service to be forwarded to the appropriate committees for privileging recommendation.

REAPPOINTMENT: Review of 5 cases by a medical staff member who maintains unproctored status for Acupuncture Privileges within the CHN/SFGH system. A summary monitoring report will be sent to the respective Clinical Service to be forwarded to the appropriate committees for reappointment recommendation.

14.42 DENTISTRY ___

Provide professional dental services to hospital and clinic patients; instruct patients in correct oral hygiene and dental care; treat mouth diseases; refer cases requiring oral surgery and medical attention to proper department.

PREREQUISITES: Requiring completion of the curriculum of an approved school of dentistry and possession of the DDS degree. Requires possession of a valid license to practice dentistry issued by the State Board of Dental Examiners.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.43 CLINICAL PSYCHOLOGY ___

Provide individual and family counseling and therapy.

PREREQUISITES: Clinical Psychologists must hold a doctoral degree in Psychology from an approved APA accredited program, and must be licensed on the basis of the doctorate degree in Psychology by the State of California, Board of Psychology.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.44 ALLERGY AND IMMUNOLOGY ___

Work-up, diagnose, consult, treat, and interpret clinical findings of adult and pediatric patients in the ambulatory setting with allergy or immunologic diseases. Core privileges include allergy skin testing and interpretation.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics or American Board of Internal Medicine and the American Board of Allergy and Immunology or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.50 WAIVED TESTING ___

Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care. By obtaining and maintaining waived testing privileges, providers satisfy competency expectations for waived testing by The Joint Commission.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics/Gynecology, or General Surgery.

PROCTORING: By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.

REAPPOINTMENT: Renewal of privileges requires every two years documentation of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.

a. Fecal Occult Blood Testing (Hemoccult®) ___

b. Vaginal Ph Testing (Ph Paper) ___

c. Urine Chemistrip® Testing ___

d. Urine Pregnancy Test (Sp® Brand Rapid Test) ___

14.60 STRAIN-COUNTERSTRAIN MANIPULATIVE MEDICINE PRIVILEGE ___

Perform manipulation principally for the purpose of relief of primarily muscular pain on the Family Medicine Inpatient Service, Family Health Center, Skilled Nursing Facility, FHC satellites, and in the patient's home.

PREREQUISITES: Successful completion, by a licensed physician, of at least 30-hours instruction and didactic training course designed for health care professionals and authorized to provide CME or CE credits. In addition, five hours of supervised clinical practice, either during or after residency or completion of training in a Doctor of Osteopathy training program.

PROCTORING: 5 direct observations and 5 cases to be reviewed by a SFGH medical staff member who either maintains Strain-Counterstrain privileges or is a Doctor of Osteopathy who has received training in the Strain-Counterstrain technique.

REAPPOINTMENT: Review of five 5 cases.

14.80 ADDICTION MEDICINE ___

Provide addiction medicine consultative services and treatment to patients in the inpatient and ambulatory settings.

PREREQUISITES: Currently board admissible, certified, or re-certified by the American Board of Addiction Medicine OR by the American Board of Preventative Medicine Addiction Medicine Subspecialty and board admissible, certified or re-certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty, American Board of Family Medicine, American Board of Pediatrics, American Board of Psychiatry and Neurology, or American Board of Emergency Medicine. Approval of the Director of the Addiction Medicine Service required for all applicants.

PROCTORING: Review of 5 cases. Review to be performed by Addiction Medicine Service Director or designee.

REAPPOINTMENT: Review of 3 cases. Review to be performed by Addiction Medicine Service Director or designee.

_______________________________________ _____________________

Addiction Medicine Director/Designee Date

90.00 CTSI (CLINICAL AND TRANSLATIONAL SCIENCE INSTITUTE) - CLINICAL RESEARCH ___

Admit and follow adult patients for the purposes of clinical investigation in the inpatient and ambulatory CTSI Clinical Research Center settings.

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by one of the boards of the American Board of Medical Specialties. Approval of the Director of the CTSI (below) is required for all applicants.

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

_______________________________________ _____________________

CTSI Medical Director Date

I hereby request clinical privileges as indicated above.

_______________________________________ _____________________

Applicant Date

APPROVED BY

____ ____________________
Division Chief Date

____ ____________________
Service Chief Date

APPENDIX F: CHART REVIEW FORMS

ZSFG Family and Community Medicine

CHART REVIEW

Provider	Site	Appt Type	Reviewer	Signature	Date
		Appt/Reappt			

MRN																				
Encounter Date																				
	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA
History, exam, and diagnostic studies reflect patient's condition and reason for visit or admission																				
Assessment and problem identification are accurate and complete																				
Therapeutic plans/regimens meet accepted standards																				
Psychosocial factors are noted and included in development of therapeutic plans																				
Problem list is reviewed and updated																				
Medication list is reviewed and updated																				
Allergies are reviewed and updated when needed																				
Health care maintenance is reviewed and updated when needed																				
Patient education is documented																				
IF SUPERVISING TRAINEES: Note reflects expected level of involvement in care of patient																				

Comments

Corrective Action None Needed Provider Counseled Topic Discussed in Staff Mtg Other:

Use this form for Privileges 14.01, 14.02, 14.03, 14.11, 14.12, 14.13, 14.41
March 2022

SFGH Family and Community Medicine

PROCEDURE REVIEW

CLINICAL PRACTICE

		Init/Reappt			
Provider	*Service*	*Appt Type*	*Reviewer*	*Signature*	*Date*

Procedure																				
MRN																				
Encounter Date																				
	Acceptable	*Improve*	*Unacceptable*	*NA*	*Acceptable*	*Improve*	*Unacceptable*	*NA*	*Acceptable*	*Improve*	*Unacceptable*	*NA*	*Acceptable*	*Improve*	*Unacceptable*	*NA*	*Acceptable*	*Improve*	*Unacceptable*	*NA*
Indication for procedure is documented, including history and exam																				
Informed consent obtained in the patient's language																				
"Time-out" procedure completed and documented																				
Procedure performed/supervised with satisfactory technical skill																				
Post-procedure education and management																				
Management of complications (if any)																				

Comments

Corrective Action None Needed Provider Counseled Topic Discussed in Staff Mtg Other:

Use this form for Privileges 14.21,14.22, 14.23, 14.24,14.25, 14.26, 14.27, 14.31, 14.32, 14.33, 14.34, 14.35, 14.36, 14.37, 14.41, 14.60

March 2022

SFGH Family and Community Medicine

CHART REVIEW—PSYCHOLOGY CARE

CLINICAL PRACTICE

Init/Reappt

Provider *Clinic* *Appt Type* *Reviewer* *Signature* *Date*

MRN																				
Encounter Date																				
	Acceptable	*Improve*	*Unacceptable*	*NA*	*Acceptable*	*Improve*	*Unacceptable*	*NA*	*Acceptable*	*Improve*	*Unacceptable*	*NA*	*Acceptable*	*Improve*	*Unacceptable*	*NA*	*Acceptable*	*Improve*	*Unacceptable*	*NA*
Statement of patient's view of problem																				
Important interpersonal relationship noted																				
Assessment of patient's problem in context of relationship.																				
Therapeutic plan noted.																				
Progress of therapeutic plan noted																				
Overall care meets high standards.																				

Comments

Corrective Action None Needed Provider Counseled Topic Discussed in Staff Mtg. Other

Use this form for Privilege 14.43

March 2022

APPENDIX G: OPPE FORM AND THRESHOLDS

	FCM OPPE 2020; updated 2024				
		Acceptable	**Marginal**	**Unacceptable**	***DATA Source***
Patient Care					
	1. SBP <150 for patients diagnosed with HTN	≥ 60%	51-59%	≤ 50%	Epic unedited
	2. Percent of Patient Panel Aged 45-75 With Up To Date Colorectal Cancer Screening	≥ 40%	25-39%	≤ 24%	Epic unedited
	3. Procedure Complications Attributable to Provider	0-1	2	≥ 3	Department Review
Medical/Clinical Knowledge					
	4. CME Activity Within Past Year	≥ 50 hours	n/a	< 50 hours	Department Review
Practice Based Learning and Improvement					
	5. Completion of ZSFG Required Annual Hospital Training Modules	Current	n/a	Not current	Medical Staff Office (MSO)
	6. Participation in Maintenance of Board Certification Activities	Current	n/a	Not current	Department Review
Interpersonal and Communication Skills					
	7. Cases of Concern/Patient Complaints/SAFE Reports/Sentinel Events	<2	2	>2	Department Review
	8. Cases of Concern/Colleague, Staff, Trainee Complaints/SAFE Reports/Sentinel Events	<2	2	>2	Department Review
Professionalism					
	9. Attendance at Monthly Department Clinical Meetings	≥ 60%	41-59%	≤ 40%	Department Review
	10. Cases of Concern/Staff Concerns/SAFE Reports/Sentinel Events	<2	2	>2	Department Review
Systems Based Practice					
	11. Primary Care: Patient Panel Size	≥ 80% of target	70-79% of target	≤ 69% of target	Epic unedited
	12. Percentage of All Attributable Notes Closed in 3 days	> 90%	80-89%	< 80%	Epic data entered by MSO

DATA SOURCES
Epic
Department Review
Medical Staff Office (MSO)

FAMILY & COMMUNITY MEDICINE
CLINICAL SERVICE RULES AND REGULATIONS
20264

FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS

I. FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE ORGANIZATION 4

A. SCOPE OF SERVICE 4
B. MEMBERSHIP REQUIREMENTS 4
C. ORGANIZATION AND STAFFING OF THE FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE 4

II. CREDENTIALING 7

A. NEW APPOINTMENTS 7
B. REAPPOINTMENTS 7
C. AFFILIATED PROFESSIONALS 7
D. STAFF CATEGORIES 7

III. DELINEATION OF PRIVILEGES 7

A. DEVELOPMENT AND ANNUAL REVIEW OF PRIVILEGES 7
B. CLINICAL PRIVILEGES AND MODIFICATION/CHANGE TO PRIVILEGES 7
C. TEMPORARY PRIVILEGES 8

IV. PROCTORING REQUIREMENTS 8

A. PROCTORING AND MONITORING REQUIREMENTS 8
B. PROCTORING AND COMPETENCY REVIEW 9
C. ADDITION OF PRIVILEGES 10
D. REMOVAL OF PRIVILEGES 10

V. EDUCATION 10

VI. FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE RESIDENT TRAINING PROGRAM AND SUPERVISION (Refer to CHN Website for Housestaff Competencies)........ 10

A. ROLE, RESPONSIBILITY AND PATIENT CARE ACTIVITIES OF RESIDENTS 10
B. EVALUATION OF RESIDENTS 11

VII. FAMILY AND COMMUNITY MEDICINE CLINICAL SERVICE CONSULTATION CRITERIA 11

VIII. DISCIPLINARY ACTION 11

IX. PERFORMANCE IMPROVEMENT/PATIENT SAFETY (PIPS) AND UTILIZATION MANAGEMENT 11

A. GOALS AND OBJECTIVES 11
B. RESPONSIBILITY 11
C. REPORTING 11
D. CLINICAL INDICATORS 12
E. CLINICAL SERVICE PRACTITIONERS PERFORMANCE PROFILES 12
F. MONITORING & EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES 12
G. MONITORING & EVALUATION OF PROFESSIONAL PERFORMANCE 12

X. MEETING REQUIREMENTS 12

XII. ADOPTION AND AMENDMENT 12

FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE
RULES AND REGULATIONS
TABLE OF CONTENTS (Continued)

APPENDICES

APPENDIX A - FAMILY & COMMUNITY MEDICINE AT ZSFG ORGANIZATIONAL STRUCTURE 13

APPENDIX B - CHIEF OF FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE JOB DESCRIPTION 14

APPENDIX C - FHC CLINICAL RESEARCH POLICY 17

APPENDIX D - ATTENDING PHYSICIAN RESPONSIBILITIES IN THE FAMILY HEALTH CENTER 18

~~APPENDIX E - ATTENDING PHYSICIAN RESPONSIBILITIES ON THE FAMILY MEDICINE INPATIENT SERVICE .... 19~~

APPENDIX E~~F~~ - FAMILY & COMMUNITY MEDICINE PRIVILEGES 20

APPENDIX F~~G~~ - CHART REVIEW FORMS .... 2~~9~~8

APPENDIX G~~H~~ - OPPE FORM AND THRESHOLDS .... 31~~2~~

I. FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE ORGANIZATION

A. SCOPE OF SERVICE

The Family and Community Medicine Clinical Service (FCM) at Zuckerberg San Francisco General (ZSFG) is responsible for: ambulatory patient care delivered in the ZSFG Family Health Center and ZSFG Urgent Care Center; medical services provided in the ZSFG Skilled Nursing Facility and the Behavioral Health Center; inpatient care delivered on the ZSFG Family Medicine Inpatient Service; and inpatient obstetrical care provided through the Prenatal Partnership Program of the Family and Community Medicine Service. The Department of Family and Community Medicine sponsors the UCSF Family and Community Medicine Residency Program, based at ZSFG.

B. MEMBERSHIP REQUIREMENTS

Membership on the Medical Staff of Zuckerberg San Francisco General Hospital is a privilege which shall be extended to those practitioners who are professionally competent and continually meet the qualifications, standards, and requirements set forth in ZSFG Medical Staff Bylaws, Rules, Regulations, and these Clinical Service Rules and Regulations.

Initial appointment will be made based on demonstrated competence in the candidate's previous training and practice. Certification or eligibility for certification by the American Board of Family Medicine (or its equivalent for individuals in specialties other than Family Medicine) is required.

C. ORGANIZATION AND STAFFING OF THE FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE

1. Organization

The Family and Community Medicine Clinical Service structure is presented on the attached organization chart (**Appendix A**). The officers of the FCM Clinical Service are the Chief of Service and the Vice-Chief of Service.

a) Chief of Service

The Chief of Service is appointed through the mechanism described in the ZSFG Medical Staff Bylaws with concurrence at the hospital level, by the Director of Public Health, and by the Chairman of the Department of Family and Community Medicine at the University of California in San Francisco. The Chief of Service fulfills the range of duties described in the ZSFG Medical Staff Bylaws. The job description for the Chief of Service is detailed in **Appendix B**.

b) Vice Chief of Service

The Vice Chief of Service is appointed by the Chief of Service, serves for an indefinite term, and serves as acting Chief of Service when the Chief of Service is unavailable.

c) Directors, Family Health Center (FHC)
The directors provide leadership and oversight of the FHC and overall direction of clinical and research activities in the FHC (see **Appendix C** for the FHC Clinical Research Policy). The directors shall develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary; coordinate the FHC's participation in the Performance Improvement and Patient Safety Program relating to the FHC; and prepare budgets and other reports in collaboration with the Nurse Manager, MSO, and/or Chief of Service.

d) Directors, Family Medicine Inpatient Service (FMIS)
The directors provide leadership and oversight of the FMIS and overall direction of the service, including clinical operations and educational activities. The directors shall develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary, and coordinate FMIS participation in the Performance Improvement and Patient Safety Program.

e) Directors, Prenatal Partnership Program (PPP)
Directors provide leadership and oversight of the PPP and overall direction of the PPP, including clinical operations and educational activities. The directors shall develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary, and coordinate the PPP's participation in the Performance Improvement and Patient Safety Program.

f) Director, Skilled Nursing Facility (SNF)
The director provides leadership and oversight of the SNF and overall direction of the SNF, including clinical operations and educational activities. The director shall develop and maintain reports, protocols, policies, procedures, and guidelines, as necessary, and coordinate the SNF's participation in the Performance Improvement and Patient Safety Program.

2. Clinical Services

a. Family Health Center
The FHC is an ambulatory care setting located on the ZSFG campus on the first and fifth floors of Building 80 and first floor of Building 90. FHC care is delivered using a Family Medicine model. Care is provided with concern for the total health care of the individual and the family, and the scope of practice is not limited by age, sex, organ system, or disease entity. Biological, clinical, and behavioral sciences are integrated in the care provided by family physicians, family nurse practitioners, and physician assistants at the FHC. Hours of operation are 8:30 a.m. to 9:00 p.m. Monday through Thursday, 8:30 a.m. to 5:00 p.m. Friday, and 8:30 a.m. to 12:00 noon on Saturday.

Comprehensive continuity care is provided with particular emphasis placed on preventive care and health maintenance. All FHC patients have an assigned primary care provider who sees them for the majority of their visits.

Urgent care for FHC patients is available on site on a drop-in basis or by appointment during the hours of operation. After-hours telephone advice is provided by a nurse advice line in collaboration with family medicine faculty members. Patients are encouraged to call for telephone advice during off hours and may be referred for evaluation at the FHC, at the ZSFG Emergency Department, Urgent Care Center, or Pediatric Urgent Care Center as appropriate.

b. ZSFG Family Medicine Inpatient Service

The FM Inpatient Service is a non-geographic adult medical service which provides acute inpatient care to FHC patients and patients enrolled in designated San Francisco Health Network clinics. The FM Inpatient Service emphasizes ongoing communication with primary care clinicians during inpatient episodes of care for patients receiving continuity of care from these clinicians. The service is staffed by UCSF FCM residents and family medicine attending physicians.

c. ZSFG Skilled Nursing Facility

The SNF is an interdisciplinary unit with medical services provided under the supervision of the SNF Medical Director, a member of the Family and Community Medicine Service. Medical care is provided by the SNF Medical Director, FCM attending physicians, and nurse practitioners, in accordance with existing policies for the SNF.

d. ZSFG Urgent Care Center

The UCC provides urgent care for patients whose primary care home is in the San Francisco Health Network, as well as patients without a primary care provider. The UCC Medical Director is a member of the Family and Community Medicine Service. UCC care is provided by physicians, nurse practitioners, and physician assistants.

e. Prenatal Partnership Program

The Prenatal Partnership Program is administered through Family and Community Medicine to provide family-centered birth services at ZSFG. Birthing services are provided by FCM physician attendings and residents and by attendings in the ZSFG Community Primary Care Service. Family physician attendings in the Community Primary Care Services who participate in the Prenatal Partnership Program receive their privileges for inpatient obstetrical care through the Family and Community Medicine Service.

f. Attending Physician Responsibilities

Overall direction of clinical care is the responsibility of the FCM attending staff either directly or through supervision of residents, affiliated medical staff members, and medical students. Requirements for FCM attending physicians are detailed in **Appendix D** ~~and E~~.

II. CREDENTIALING

A. NEW APPOINTMENTS

The process of application for membership to the ZSFG Medical Staff through FCM is in accordance with ZSFG Bylaws, Rules, and Regulations, as well as with these Clinical Service Rules and Regulations.

B. REAPPOINTMENTS

The process of reappointment to the ZSFG Medical Staff through FCM is in accordance with ZSFG Bylaws, Rules, and Regulations, as well as with these Clinical Service Rules and Regulations.

1) **Modification of Clinical Service**
The process for modification of FCM clinical services will be through the appropriate required review process.

2) **Staff Status Change**
The process for Staff Status Change for FCM members is in accordance with ZSFG Bylaws, Rules, and Regulations.

3) **Modification/Changes to Privileges**
The process for modification or change to privileges for FCM members is in accordance with ZSFG Bylaws, Rules, and Regulations.

C. AFFILIATED PROFESSIONALS

The process of appointment and reappointment of affiliated professionals to the ZSFG Medical Staff through FCM is in accordance with ZSFG Bylaws, Rules, and Regulations, as well as with these Clinical Service Rules and Regulations.

D. STAFF CATEGORIES

FCM staff members fall into the same categories described in the ZSFG Bylaws and Rules and Regulations, as well as in these Clinical Service Rules and Regulations.

III. DELINEATION OF PRIVILEGES

A. DEVELOPMENT AND ANNUAL REVIEW OF PRIVILEGES

FCM privileges are developed in accordance with ZSFG Medical Staff Bylaws, Rules, and Regulations, as well as with these Clinical Service Rules and Regulations.
The FCM Privilege Request Form shall be reviewed annually by the Chief of Service.

B. CLINICAL PRIVILEGES AND MODIFICATION/CHANGE TO PRIVILEGES

(Refer to **Appendix EF**)

1. FCM clinical privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Rules, and Regulations. All requests for clinical privileges will be evaluated and approved by the Chief of Service.

2. The process for modification or change to privileges of FCM members is in accordance with the ZSFG Medical Staff Bylaws, Rules, and Regulation.

3. FCM grants privileges to clinicians working in the ZSFG FHC, UCC, FMIS, SNF, BHC, and Birth Center.

a) Request for clinical privileges will be evaluated by the Chief of Service. The initial determination of such requests shall be based on the applicant's education, training, experience, and demonstrated competence. The applicant shall have the burden of establishing his/her qualifications and competency for the clinical privileges requested.

b) FCM privileges permit practice within the ZSFG FHC, UCC, FMIS, SNF, BHC, Birth Center, and in related sites (e.g., patients' homes).

c) Evidence must be presented of having training and successful experience for each privilege requested.

C. TEMPORARY PRIVILEGES

Temporary privileges shall be authorized in accordance with the ZSFG Medical Staff Bylaws, Rules, and Regulations.

IV. PROCTORING AND MONITORING

A. PROCTORING AND MONITORING REQUIREMENTS

FCM proctoring and monitoring requirements shall be the responsibility of the Chief of Service, with the primary review delegated to the medical directors of the FHC, FMIS, UCC, SNF, and PPP.

The scope of individual provider activity is determined by level of training and skills obtained in special procedure training. Clinical competence is monitored through direct

observation, chart review, and practice audits. In general, the scope of provider activity is in keeping with that defined by the American Board of Family Medicine and the Accreditation Council of Graduate Medical Education (ACGME) Residency Review Committee for Family Medicine. All care delivered by non-licensed residents is directly supervised by an attending physician in both the inpatient and outpatient settings. Licensed residents may be indirectly supervised only after meeting criteria outlined by the FCM Residency Program Clinical Competence Committee. The FM Inpatient Service physician of record is always a family physician faculty member.

B. PROCTORING AND COMPETENCY REVIEW

1. INITIAL APPOINTMENT

Initial appointment will include review of qualifications, prerequisites, and previous experience for each privilege requested. The privileges request form (**Appendix E~~F~~**) specifies the qualifications, prerequisites, and proctoring requirements for each privilege. Proctoring for initial appointment will include direct observation, case review, and review of the medical record. Forms used for documentation of case reviews are included in **Appendix F~~G~~**.

The Medical Directors perform or assign proctoring. In instances when these individuals are the candidates to be proctored, the Chief of Service or designee will be assigned as proctor. The Chief of Service will be reviewed by the vice Chief of Service.

If the minimum number of proctored cases is insufficient for making a valid determination of clinical competence, proctoring will continue until a valid determination of clinical competence is achieved. This determination will be made jointly by the proctor and the Chief of Service.

A summary proctoring report will be sent to the Chief of Service for review and approval.

2. REAPPOINTMENT

a. Following initial appointment, review will be performed prior to each reappointment. The Chief of Service will be responsible for this evaluation. The evaluation will be based on a combination of concurrent assessment by the medical directors and clinical data sources for ambulatory and inpatient care.

b. Clinical performance data for review will consist of the following.

i. Chart review: A minimum number of cases and charts will be reviewed for each privilege for which the clinician is credentialed, as outlined in the FCM privileges form (**Appendix F**).

ii. Clinical indicators and practice profiles: These indicators will be reviewed for the entire population of patients for whom the

clinician had primary clinical responsibility during the two-year period preceding reappointment. These will be reported to the provider and the ZSFG Medical Staff Office every 11 months as an Ongoing Professional Practice Evaluation (OPPE).

iii. Case presentation: At least once during the reappointment period, each physician will present, to the FCM faculty, a patient case or cases for which he/she is clinically responsible.

iv: Other information as appropriate, including unusual incidence reports, adverse drug reaction reports, and similar information collected by ZSFG committees.

c. The Chief of Service will be reviewed by the Vice Chief of Service.

C. ADDITION OF PRIVILEGES

Requests for additional FCM privileges shall be in accordance with ZSFG Bylaws, Rules, and Regulations.

D. REMOVAL OF PRIVILEGES

Requests for removal of FCM privileges shall be in accordance with ZSFG Bylaws, Rules, and Regulations.

V. EDUCATION

The following FCM educational opportunities are regularly offered:

- Department of Family and Community Medicine Grand Rounds, monthly
- FCM Clinical Staff Meetings, monthly
- Morbidity and Mortality Conference, monthly
- Case conferences at attending faculty meetings, monthly
- Faculty Development Sessions, minimum three per year
- Other FCM-sponsored seminars and conferences

VI. FAMILY & COMMUNITY MEDICINE RESIDENT TRAINING PROGRAM AND SUPERVISION (Refer to SFHN Website for House staff Competencies)

Attending faculty shall supervise residents in such a way that house staff assumes progressively increasing responsibility for patient care according to level of training, ability, and experience.

A. ROLE, RESPONSIBILITY, AND PATIENT CARE ACTIVITIES OF RESIDENTS

Residents are trained in accordance with ACGME, American Board of Family Medicine, UCSF, ZSFG, and California Medical Board guidelines.

B. EVALUATION OF RESIDENTS

Residents are evaluated in accordance with ACGME guidelines for both inpatient and outpatient care. The evaluation process consists of written rotation evaluations, written outpatient evaluations, and written evaluations of required didactic presentations. The FCM Residency Program Clinical Competence Committee reviews evaluations for each resident twice yearly and advises the Residency Program Director through a summary evaluation and promotion recommendations.

VII. FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE CONSULTATION CRITERIA

Consultation in all categories of privileges will be expected for patients whose condition is critical, deteriorating, unresponsive to the therapy initiated, or when diagnostic problems remain unresolved.

VIII. DISCIPLINARY ACTION

The ZSFG Bylaws, Rules, and Regulations will govern all disciplinary action involving FCM members.

IX. PERFORMANCE IMPROVEMENT/PATIENT SAFETY AND UTILIZATION MANAGEMENT

A. GOALS AND OBJECTIVES

The Chief of Service, or designee, is responsible for evaluation and improvement of clinical performance, for ensuring patient safety, and for identifying and implementing solutions to quality-of-care issues. As necessary, assistance is invited from other departments, the Performance Improvement/Patient Safety Committee, or the appropriate administrative committee or organization.

B. RESPONSIBILITY

Overall responsibility for performance improvement lies with the Chief of Service. A Director of Quality Improvement is appointed by the Chief of Service to supervise and coordinate performance improvement activities and to serve as the FCM representative to the ZSFG Performance Improvement and Patient Safety Committee. In collaboration with the FCM Director of Quality Improvement, medical directors of FCM clinical programs will be responsible for collecting and reviewing performance improvement indicator data and reviewing any adverse events. At least eight times per year, the FCM clinical staff will meet to discuss, review, and plan performance improvement activities.

C. REPORTING

Performance Improvement and Patient Safety (PIPS) and Utilization Management (UM) activity records will be maintained by FCM. Minutes are available for review of ZSFG Medical Staff Services.

D. CLINICAL INDICATORS

In collaboration with the ZSFG PIPS Department, a calendar of review of clinical indicators of patients is established for each year. The PIPS Department monitors these throughout the year through data, chart, and patient panel reviews. This information, along with the information gathered from the PIPS Department is compiled and presented to the ZSFG PIPS committee.

E. CLINICAL SERVICE ONGOING PROFESSIONAL PRACTICE EVALUATIONS

In collaboration with the ZSFG Performance Improvement and Patient Safety Department, FCM selects clinical indicators to monitor the performance of each physician with primary direct clinical responsibility for a population of patients. These Ongoing Professional Practice Evaluations (OPPEs; see **Appendix ~~H~~G**) are produced, reviewed, and disseminated to each provider by the Chief of Service. OPPEs for all physicians are compiled and presented to the ZSFG Medical Staff Office every eleven months.

F. MONITORING AND EVALUATION OF APPROPRIATENESS OF PATIENT CARE SERVICES

FCM monitors and evaluates each practitioner for appropriateness of patient care, and the Chief of Service maintains these records.

G. MONITORING AND EVALUATION OF PROFESSIONAL PERFORMANCE

FCM monitors and evaluates each practitioner, and the Chief of Service maintains these records. OPPE clinical indicators and thresholds are detailed in **Appendix G~~H~~**.

X. MEETING REQUIREMENTS

In accordance with ZSFG Bylaws, all active members are expected to show good-faith participation in the governance and quality evaluation process by attending a minimum of 50% of all committee meetings assigned, clinical service meetings, and the annual Medical Staff Meeting.

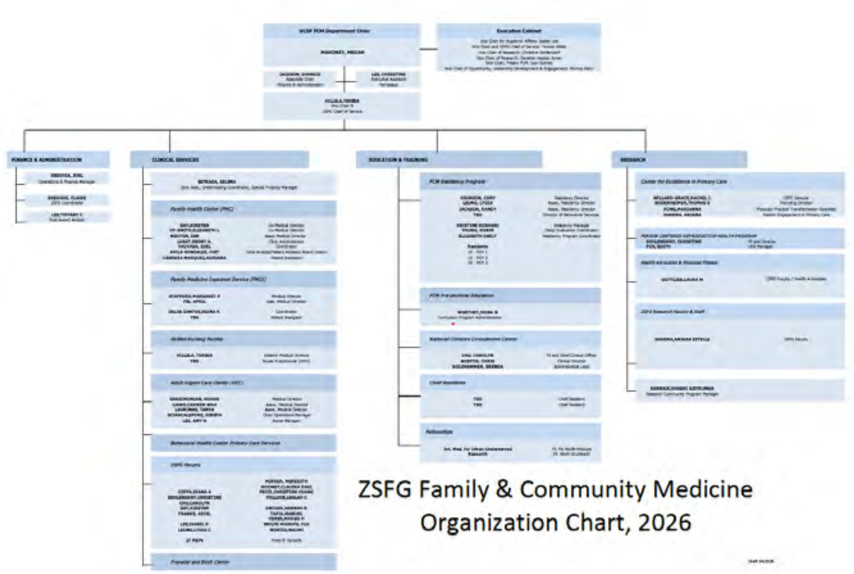
FCM members shall meet as frequently as necessary, but at least quarterly, to consider findings from ongoing monitoring and evaluation of the quality and appropriateness of the care and treatment provided to patients.

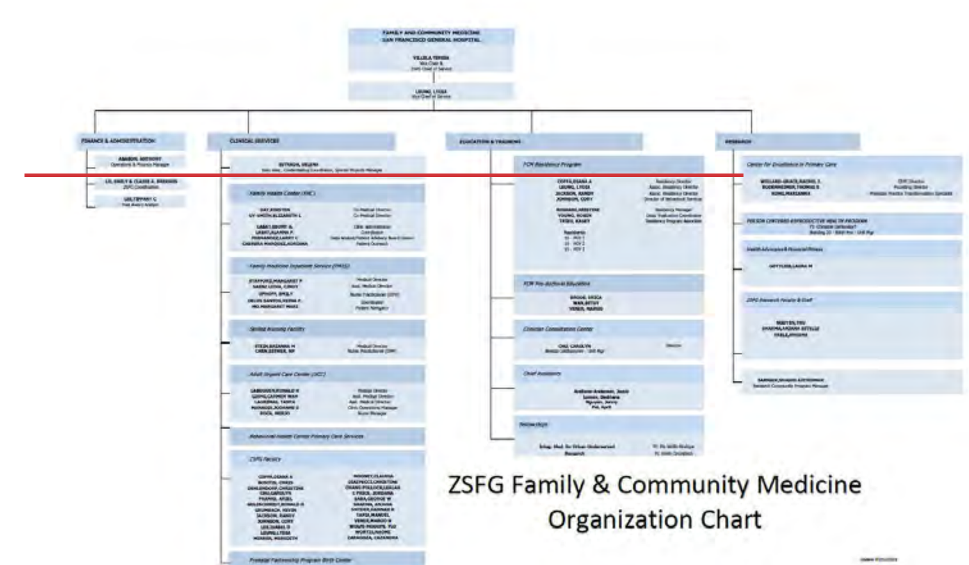
As defined in the ZSFG Bylaws, a quorum is constituted by at least three (3) voting members of the active staff for the purpose of conducting business.

XI. ADOPTION AND AMENDMENT

The FCM Rules and Regulations will be adopted and revised annually by a majority vote of all active service members.

APPENDIX A: FAMILY & COMMUNITY MEDICINE ORGANIZATIONAL STRUCTURE




ZSFG Family & Community Medicine
Organization Chart

APPENDIX B:
JOB DESCRIPTION, CHIEF OF ZSFG FAMILY & COMMUNITY MEDICINE CLINICAL SERVICE

Chief, Family and Community Medicine Service

Zuckerberg San Francisco General Hospital

The primary responsibility of the Chief of the ZSFG Family and Community Medicine Service (FCM) is to assure the integrity and quality of the clinical services administered by the UCSF Department of Family and Community Medicine at Zuckerberg San Francisco General Hospital (ZSFG). The Chief of Service has direct accountability to the Chief of the ZSFG Medical Staff and the UCSF Associate Dean at ZSFG, in addition to the Chair of the UCSF Department of Family and Community Medicine and the ZSFG Executive Administrator. The Medical Directors of FCM-administered clinical services at ZSFG report to the FCM Chief of Service. The Chief of Service works in close collaboration with the other ZSFG chiefs of service and ZSFG nursing and administrative leaders to promote the collective excellence and accountability of ZSFG services and programs.

The Chief of Service, in consultation with the Chair of the UCSF Department of Family and Community Medicine, has responsibility for recruiting and supervising faculty members of the department who are based at ZSFG. With the support of the department's manager at ZSFG, the Chief of Service is responsible for managing the department's funds related to ZSFG professional fee income, the Affiliation Agreement between UCSF and the City and County of San Francisco, other funds involving ZSFG clinical operations, and such other funds as the Chair of 77the Department delegates to be principally managed by the Chief of Service.

The Chief of Service works closely with the Director of the UCSF-ZSFG Family and Community Medicine Residency Program to assure the integrity of the residency training program and the integration of the training program into the clinical services at ZSFG, including assuring compliance with hospital rules and regulations, ACGME standards, and related policies and regulations. The Chief of Service also works closely with the department's Director of Predoctoral Education to assure successful operation of FCM medical student teaching programs at ZSFG and works with educational leaders of the other UCSF health professional schools on issues relating to students' educational experiences on FCM clinical services.

The Chief of Service works in collaboration with the Chair of the UCSF Department of Family and Community Medicine to enhance the academic environment for the department's programs based at ZSFG, including research and community service.

The Chief of Service is expected to serve as an attending physician on the ZSFG Medical Staff and perform direct patient care as part of the FCM Service. At a minimum, the Chief of Service is expected to have a continuity family medicine practice and supervise residents and medical students at the Family Health Center. Ideally, the Chief of Service will serve as an attending physician on the Family Medicine Inpatient Service and/or Perinatal Partnership Program family medicine obstetrical call group.

As a member of the UCSF faculty, the Chief of Service is expected to be involved in scholarly activities and contribute to the generation and translation of knowledge in areas of inquiry relevant to family medicine. The extent of involvement in research and scholarly activities will be based on the interests and qualifications of the Chief of Service.

The UCSF-City and County of San Francisco Affiliation Agreement and ZSFG Medical Staff Bylaws fully delineate the responsibilities of chiefs of service, including the following:

A. ADMINISTRATION

1. General Responsibilities

a) Be responsible and accountable to the governing body through the Medical Executive Committee (MEC) for the clinical and administratively related activities within the clinical service;

b) Be a participating member of the MEC;

c) Be responsible for the integration of the clinical service into the primary functions of the organization;

d) Be responsible for the coordination and integration of inter- and intra-departmental services;

e) Provide administrative leadership for a culturally sensitive and competent program to the community served by ZSFG; and

f) Provide administrative leadership for a culturally sensitive environment for UCSF and ZSFG employees and trainees.

2. Planning

a) Provide direction and participate in the planning, implementation and evaluation of the organization's plan for patient care;

b) Assess the effect of UCSF academic and program planning upon ZSFG and directly communicate this information as part of the joint UCSF/ZSFG program planning;

c) Stay abreast of changes in the health care industry, both locally as well as industry-wide, and demonstrate leadership by identifying and implementing appropriate changes; and

d) Assist in the preparation of annual reports, including budgetary planning, pertaining to the clinical service as may be required by the Chief of Staff, the MEC, the Associate Dean, Executive Administrator, or the Governing Body.

3. Resource Management

Manage City and University resources, including revenue and expenses, appropriately and in a timely manner, as evidenced by:

a) Appropriate budget preparation and monitoring based on service goals;

b) Maximizing reimbursement and other revenues;

c) Ensuring compliance with third party billing regulations, including timely and appropriate documentation in the medical record;

d) Ensuring effective utilization of assigned clinical, administrative and research space;

e) Adhering to UCSF and ZSFG financial policies; and

f) Reporting and recommending to hospital management, when necessary, with respect to matters affecting patient care in the clinical service, including personnel, space and other resources, supplies, special regulations, standing orders and techniques;

4. Operations Management

a) Designate an acting chief when the Chief of Service will be absent for a period longer than 24 hours but less than 30 days. After thirty (30) days, the process described in the Medical Staff Bylaws will be followed;

b) Assume responsibility for orienting new members and enforce the Medical Staff Bylaws, Rules, Regulations, and Policies, the clinical service rules and regulations, and the hospital's policies and procedures within the respective clinical service;

c) Participate in the administration of the Clinic Service through cooperation with the Nursing Service, Hospital Administration and all personnel involved in matters affecting patient care.

B. COMMUNICATION

1. Communicate appropriately with hospital administration, the ZSFG Dean's Office and Department faculty and staff;
2. Communicate information to faculty, residents, and students;
3. Promote effective communication and collaboration among health care professionals; and
4. Develop and maintain appropriate relationships within the San Francisco community.

C. PERFORMANCE IMPROVEMENT

1. Monitor and evaluate the quality and appropriateness of patient care provided within the clinical service, utilizing a quality improvement program that measures patient care outcomes;
2. Monitor the professional performance of all individuals who have clinical privileges in the clinical service, and report thereon to the Credentials Committee as part of the Reappointment process and at such other times as may be indicated;
3. Appoint ad hoc committees or working groups, as necessary, to carry out quality improvement activities;
4. Demonstrate the ability to assess issues and effectively solve problems; and
5. Implement and monitor agreed-upon standards for program operations; address performance problems effectively and in a timely manner.

D. MEDICAL STAFF CREDENTIALING AND PRIVILEGING

1. Recommend criteria for clinical privileges in the clinical service;
2. Recommend sufficient number of qualified and competent individuals to provide care/clinical services;
3. Make a report to the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for all applicants seeking privileges in the clinical service;
4. Make recommendations to the Credentials Committee regarding the qualifications and competence of clinical service personnel who are affiliated professional staff; and
5. Assume responsibility for the evaluation of all provisional appointees and report thereon to the Credentials Committee.

E. EDUCATION AND RESEARCH

1. Be accountable to the Associate Dean and the UCSF Department Chair for the conduct of graduate and undergraduate medical education and UCSF-based research programs conducted in the FCM Clinical Service;
2. Assume responsibility for the establishment, implementation and effectiveness of the orientation, teaching, education and research programs in the Clinical Service; and
3. Ensure the quality of resident teaching by monitoring outcomes.

Updated 2020

APPENDIX C: FHC CLINICAL RESEARCH POLICY

Zuckerberg San Francisco General Hospital
Family Health Center
Date Adopted: 5/02
Reviewed: 6/04, 05/16
Revised: 9/05, 05/16

TITLE: *Criteria for Approval of Research Studies at the Family Health Center*

STATEMENT OF POLICY**: It is the policy of the Family Health Center to require researchers conducting studies which involve FHC patients to meet clear hospital and clinic guideline.**

POLICY: For research to be conducted at the FHC the following requirements must be met:

1. Minimal additional administrative work for FHC staff or providers.
2. No obvious duplication of patient contacts by concurrent research studies.
3. Letters to patients are not signed by FHC staff or providers. There is no implication of FHC provider involvement, unless appropriate.
4. Providers are given patient lists for review prior to patient contact.
5. Study is relevant to our patients, and appropriate patient incentives are included.
6. Research group will present outcome of study for FPRP/FHC during noon conference or All Team Meeting.
7. Study must be approved by the appropriate IRB/CHR.
8. The FHC requests that all studies involving FHC patients make a voluntary donation to the clinic. The suggested donation range is $50-$500, depending on the total study budget. If this would represent a hardship, please let us know and we can discuss your circumstances. These funds are used to support FHC staff development and team-building activities.

Researchers will follow these steps:

1. Initial contact by research study group to Medical Director.
2. Letter sent to research group which outlines FHC criteria for approval of research studies.
3. If study group believes they do or can meet all criteria, protocol is sent to FHC Medical Director.
4. Protocol is reviewed by Management Team with consultation by Teresa Villela, Chief of Service.
5. Research study group gives lists of potential patient contacts to primary care providers for review.
6. Final list of contacts is given to Medical Director.
7. Study proceeds.

Approved by:

Lydia Leung, M.D.
Medical Director, Family Health Center

APPENDIX D: ATTENDING PHYSICIAN RESPONSIBILITIES FAMILY HEALTH CENTER

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Contents

Quick Links & Important Documents 2
Expectations 3
Points of Contact 3
  Clinical Support 3
  Residency Support 4
  Administrative Support 4
Schedules 5
  Sick calls or emergency situations for **PCPs** 5
  Sick calls or emergency situations for **Preceptors** 5
Precepting Session (Overview) 6
  Before/Start of precepting session 6
  During each clinic session, your primary responsibilities 7
    If there are active issues (patients sick or further evaluation needed) beyond 12pm 7
    If there are active issues (patients sick or further evaluation needed) beyond 5pm 8
    If patients need direct admission to SFGH 8
    If patients need to be transferred to ED for higher level of care and evaluation 8
    If you have any urgent clinical or non-clinical questions or issues that you do not feel comfortable with, please contact: 8
Evaluations of learners 9
  For all learners 9
  For residents 9
Precepting Residents 9
  Before you precept 9
  Precepting documentation guidelines 9
Working with Clinician of the Day (COD) 11
  Resident Backup 11
81 Attending Responsibilities 11
  FHC Same-Day Drop-in clinic 11
  Your role as attending for Drop-in clinic 11
    Rx Requests / Prescription Refills: 12
  Help check resident InBaskets: 12
  Best Practices for 81 attending: 13
85/91 Attending Responsibilities 13

1

Contents

Quick Links & Important Documents 2
Expectations 3
Points of Contact 3
- Clinical Support 3
- Residency Support 4
- Administrative Support 4

Schedules 5
- Sick calls or emergency situations for **PCPs** 5
- Sick calls or emergency situations for **Preceptors** 5

Precepting Session (Overview) 6
- Before/Start of precepting session 6
- During clinic session, here are your primary responsibilities 7
  - If there are active issues (patients sick or further evaluation needed) beyond 12pm 7
  - If there are active issues (patients sick or further evaluation needed) beyond 5pm 7
  - If patients need direct admission to SFGH 7
  - If patients need to be transferred to ED for higher level of care and evaluation 7
  - If you have any urgent clinical or non-clinical questions or issues that you do not feel comfortable with, please contact: 8

Evaluations of learners 8
- For all learners 8
- For residents 8

Precepting Residents 9
- Before you precept 9
- Precepting documentation guidelines 9

Working with Clinician of the Day (COD) 10
- Resident Backup 10

81 Attending Responsibilities 10
- FHC Same-Day Drop-in clinic 10
- Your role as attending for Drop-in clinic 10
  - Rx Requests / Prescription Refills: 11
- Help check resident InBaskets 11
- Best Practices: 12

85 Attending Responsibilities 12
- Resident teaching: 12
  - Patient Calls, medication refills and review documents 12
  - Review labs and diagnostic studies 13
- Help check resident InBaskets 13
- Zoom attending 13
- Newcomers Health Program (NHP) 14
- Best Practices: 14

Intern Linkage Attending Responsibilities 14
Evening Clinic Attending Responsibilities 15
Checklist for Onboarding & LT Internal updates 15

*Full content at: https://ucsf.app.box.com/s/jyfyo3d3kmcreaf3pzfm06d4zdg9ksee

Revised 6.22.23

1

APPENDIX EF: FAMILY & COMMUNITY MEDICINE PRIVILEGES

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FOR ALL PRIVILEGES
All complication rates, including problem transfusions, deaths, unusual occurrence reports and sentinel events, as well as Department quality indicators, will be monitored semiannually.

14.00 OUTPATIENT CLINIC PRIVILEGES ___

14.01 AMBULATORY CARE PRIVILEGES FOR FAMILY MEDICINE PREPARED PHYSICIANS ___
Perform basic procedures within the usual and customary scope of Family Medicine: diagnosis, management, treatment, preventive care, and minor procedures for patients of all ages in the Family Health Center (FHC), FHC satellites, or the patient's home. All procedures requiring anesthesia to be performed under local anesthesia. May refer patients for admission to the appropriate Inpatient Service, and may write informational notes in the SFGH inpatient medical record.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.02 AMBULATORY CARE PRIVILEGES FOR INTERNAL MEDICINE OR EMERGENCY MEDICINE PREPARED PHYSICIANS ___
Perform basic procedures within the usual and customary scope of Internal Medicine or Emergency Medicine: diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the Family Health Center (FHC), FHC satellites, or the patient's home. All procedures requiring anesthesia to be performed under local anesthesia. May refer patients for admission to the appropriate Inpatient Service and may write informational notes in the SFGH inpatient medical record.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Internal Medicine, the American Board of Emergency Medicine.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.03 BEHAVIORAL HEALTH CENTER PRIVILEGES ___
Performs basic procedures within the usual and customary scope of Family Medicine or Internal Medicine: diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the Behavioral Health Center.

Concurrence of Behavioral Health Center Medical Director required:

____

Signature, Behavioral Health Ctr Medical Director Date

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-certified by the American Board of Family Medicine, or the American Board of Internal Medicine.

PROCTORING: Review of 5 cases

REAPPOINTMENT: Review of 3 cases

14.10 INPATIENT CARE PRIVILEGES ___
Admit and be responsible for hospitalized adults. Admissions may include medical, surgical, gynecological, and neurological problems, and medical complications in pregnant patients with obstetric consultation. May also follow patients admitted to critical care units in a consultative capacity.

14.11 FAMILY MEDICINE INPATIENT SERVICE PRIVILEGES ___
Perform basic procedures within the usual and customary scope of Family Medicine: diagnosis, management, treatment, preventive care, and minor procedures for hospitalized adults.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.12 SKILLED NURSING FACILITY CARE PRIVILEGES ___
Perform basic procedures within the usual and customary scope of Family Medicine or Internal Medicine: diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the SFGH Skilled Nursing Facility (SNF).

Concurrence of Skilled Nursing Facility Medical required:

____ ______________________
Signature, Skilled Nursing Facility Medical Director Date

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified byt the American Board of Family Medicine, the American Board of Internal Medicine.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.13 NURSERY PRIVILEGES ___
Render care to well newborns, including admitting and performing routine evaluations and management.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

PROCTORING: Case review for 3 newborn admissions

REAPPOINTMENT: Case review of 2 newborn admissions

14.20 PERINATAL PRIVILEGES ___
Render care to women during the perinatal period, including specific privileges 14.21 through 14.27, if requested and approved below:

14.21 NORMAL VAGINAL DELIVERY ___
Including administration of local anesthesia, performance of episiotomy, and repair of lacerations other than those involving the rectal sphincter.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

PROCTORING: Case review and direct observation of a minimum of 3 deliveries.

REAPPOINTMENT: Review of 3 cases.

14.22 VACUUM ASSISTED DELIVERIES (OB CONSULTATION REQUIRED) ___

Concurrence of the Chief of OB/Gyn required:

____ ______________________
Signature, chief of OB/GYN Date

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine.

PROCTORING: For applicants with documentation of prior successful performance of a minimum of 25 vacuum assisted deliveries: case review and direct observation of a minimum of 2 deliveries using vacuum assistance. For applicants with documentation of fewer than 25 vacuum assisted deliveries: case review and direct observation of 5 deliveries using vacuum assistance.

REAPPOINTMENT: Case review of 1 delivery using vacuum assistance.

14.23 FIRST ASSIST IN CESAREAN DELIVERY (OBSTETRICS CONSULTATION REQUIRED) ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine and documentation of prior successful performance of a minimum of 25 Cesarean deliveries.

PROCTORING: Case review and direct observation of 5 Cesarean deliveries.

REAPPOINTMENT: Case review of 1 Cesarean delivery.

Concurrence of the Chief of OB/Gyn required:

____ ____________________
Signature, Chief of OB/GYN Date

14.24 ULTRASOUND IN PREGNANCY ___

Limited to determination of fetal gestational age, confirmation of presentation, placenta location, amniotic fluid adequacy, and confirmation of fetal heart rate.

a. Basic First and Second Trimester Ultrasound (for dating, viability and location of pregnancy) ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine and documentation of a minimum of 8 hours instruction and didactic training in ultrasound technology and imaging.

PROCTORING: For providers with documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution (residency or medical staff): case review and direct observation of 5 dating ultrasounds.For providers without documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution: 8 hour obstetric ultrasound course followed by direct observation of 10 dating ultrasounds and a further retrospective review of an additional 10 dating ultrasound cases/images.

REAPPOINTMENT: Retrospective review of four (4) cases/images in the past 2 years.

b. Limited Third Trimester Ultrasound (assessment of viability, fetal position, placental location, single deepest pocket of amniotic fluid) ___

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine and documentation of a minimum of 8 hours instruction and didactic training in ultrasound technology and imaging.

PROCTORING: For providers with documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution (residency or medical staff): case review and direct observation of 5 limited third trimester ultrasounds.
For providers without documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution: 4 hour obstetric ultrasound course followed by case review and direct observation of 5 limited third trimester ultrasounds.

REAPPOINTMENT: Retrospective review of two (2) cases/images in the past 2 years.

14.25 External Cephalic Version ___

PREREQUISITES: Currently admissible, certified, or recertified by the American Board of Family Medicine; active FCM Cesarean delivery privileges; and documentation of a minimum of 2 procedures.

PROCTORING: Concurrent review of 2 cases.

REAPPOINTMENT: Case reviews done in accordance with Obstetrics and Gynecology department quality improvement process.

14.26 CESAREAN DELIVERY ___

PREREQUISITES: Currently admissible, certified, or recertified by the American Board of Family Medicine; completion of 12-month fellowship including training in operative obstetrics; and documentation of a minimum of 50 Cesarean deliveries or active Cesarean delivery privileges within the last 5 years.

PROCTORING: Concurrent review of 5 Cesarean deliveries.

REAPPOINTMENT: Satisfactory performance of a minimum of 10 Cesarean deliveries in 2 years. Case reviews done in accordance with Obstetrics and Gynecology department quality improvement process.

Concurrence of the Obstetrics and Gynecology Service Chief required.

____
Signature, Obstetrics and Gynecology Service Chief

14.27 POSTPARTUM STERILIZATION ___

Prerequisites: Currently admissible, certified, or recertified by the American Board of Family Medicine; and documentation of a minimum of 10 procedures within the last 2 years.

Proctoring: Concurrent review of 2 cases.

Reappointment: Case reviews done in accordance with Obstetrics and Gynecology department quality improvement process.

14.30 SPECIAL PRIVILEGES ___

Physicians may apply for each of the following procedural privileges separately based on qualifications and scope of practice.

14.31 LUMBAR PUNCTURE ___

PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).

PROCTORING: Review of 2 cases, one of which may be performed on a simulated model.

REAPPOINTMENT: Review of 2 cases, one of which may be performed on a simulated model.

14.32 PARACENTESIS ___

PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).

PROCTORING: Review of 2 cases, one of which may be performed on a simulated model.

REAPPOINTMENT: Review of 2 cases, one of which may be performed on a simulated model.

14.33 THORACENTESIS ___

PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).

PROCTORING: Review of 2 cases, one of which may be performed on a simulated model.

REAPPOINTMENT: Review of 2 cases, one of which may be performed on a simulated model.

14.34 PLACEMENT OF CENTRAL VENOUS CATHETER, INCLUDING FEMORAL VENOUS CATHETER ___

PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).

PROCTORING: Review of 2 cases, one of which may be performed on a simulated model.

REAPPOINTMENT: Review of 2 cases, one of which may be performed on a simulated model.

14.35a ENDOMETRIAL BIOPSY

PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Perinatal Privileges (14.20).

PROCTORING: Review of 2 cases.

REAPPOINTMENT: Review of 2 cases.

14.35b INTRAUTERINE DEVICE (IUD) INSERTION

PREREQUISITES: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Perinatal Privileges (14.20).

PROCTORING: Review of 2 cases.

REAPPOINTMENT: Review of 2 cases.

14.36 SURGICAL TERMINATION OF FIRST TRIMESTER INTRAUTERINE PREGNANCY
Perform surgical abortions in the first trimester of pregnancy at appropriate facilities at SFGH.

PREREQUISITES: Currently Board Admissible, Board Certified or Re-Certified by the American Board of Family Medicine. Completion of at least 20 hours of formal training in surgical abortion, including first trimester ultrasound for confirmation of intrauterine pregnancy and determination of gestational age, during residency or a CME program, and documentation of 50 procedures.

PROCTORING: Case review of 3 surgical terminations.

REAPPOINTMENT: Case review of 2 terminations.

14.37 VASECTOMY

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Family Medicine. Completion, as a licensed physician, of a minimum of 20 vasectomy procedures under supervision of a privileged and Board Certified Urologist or Family Physician.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.38 CIRCUMCISION

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics or American Board of Family Medicine. Documentation of proficiency from a Residency program with at least 5 cases, OR, documentation of previous privileges at another hospital with at least 5 cases, OR, minimum of 5 cases performed with assistance from a supervising attending with circumcision privileges, until provider and supervisor determine the provider can perform under proctoring.

PROCTORING: Direct observation of 3 independently performed cases (consecutive/concurrent).

REAPPOINTMENT: Review of 3 cases.

14.40 LIMITED AMBULATORY CARE PRIVILEGES

14.41 ACUPUNCTURE
Perform acupuncture, acupressure, and moxibustion in the Family Medicine Inpatient Service, Family Health Center (FHC), Skilled Nursing Facility, FHC Satellites and in the patient's home.

PREREQUISITES: Successful completion, by a licensed physician of at least 200-hours instruction and didactic training course given by a UC or other nationally recognized university.

PROCTORING: 5 direct observations and 5 cases to be reviewed by a medical staff member who maintains unproctored status for Acupuncture Privileges within the CHN/SFGH system. Direct observations and chart reviews may be on the same patient or on different patients. A summary monitoring report will be sent to the respective Clinical Service to be forwarded to the appropriate committees for privileging recommendation.

REAPPOINTMENT: Review of 5 cases by a medical staff member who maintains unproctored status for Acupuncture Privileges within the CHN/SFGH system. A summary monitoring report will be sent to the respective Clinical Service to be forwarded to the appropriate committees for reappointment recommendation.

14.42 DENTISTRY
Provide professional dental services to hospital and clinic patients; instruct patients in correct oral hygiene and dental care; treat mouth diseases; refer cases requiring oral surgery and medical attention to proper department.

PREREQUISITES: Requiring completion of the curriculum of an approved school of dentistry and possession of the DDS degree. Requires possession of a valid license to practice dentistry issued by the State Board of Dental Examiners.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.43 CLINICAL PSYCHOLOGY
Provide individual and family counseling and therapy.

PREREQUISITES: Clinical Psychologists must hold a doctoral degree in Psychology from an approved APA accredited program, and must be licensed on the basis of the doctorate degree in Psychology by the State of California, Board of Psychology.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.44 ALLERGY AND IMMUNOLOGY
Work-up, diagnose, consult, treat, and interpret clinical findings of adult and pediatric patients in the ambulatory setting with allergy or immunologic diseases. Core privileges include allergy skin testing and interpretation.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by the American Board of Pediatrics or American Board of Internal Medicine and the American Board of Allergy and Immunology or special dispensation from the chief of service for equivalent training.

PROCTORING: Review of 5 cases.

REAPPOINTMENT: Review of 3 cases.

14.50 WAIVED TESTING
Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care. By obtaining and maintaining waived testing privileges, providers satisfy competency expectations for waived testing by The Joint Commission.

PREREQUISITES: Currently Board Admissible, Board Certified, or Re-Certified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics/Gynecology, or General Surgery.

PROCTORING: By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.

REAPPOINTMENT: Renewal of privileges requires every two years documentation of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.

a. Fecal Occult Blood Testing (Hemoccult®) ___

b. Vaginal Ph Testing (Ph Paper) ___

c. Urine Chemistrip® Testing ___

d. Urine Pregnancy Test (Sp® Brand Rapid Test) ___

14.60 STRAIN-COUNTERSTRAIN MANIPULATIVE MEDICINE PRIVILEGE ___
Perform manipulation principally for the purpose of relief of primarily muscular pain on the Family Medicine Inpatient Service, Family Health Center, Skilled Nursing Facility, FHC satellites, and in the patient's home.

PREREQUISITES: Successful completion, by a licensed physician, of at least 30-hours instruction and didactic training course designed for health care professionals and authorized to provide CME or CE credits. In addition, five hours of supervised clinical practice, either during or after residency or completion of training in a Doctor of Osteopathy training program.

PROCTORING: 5 direct observations and 5 cases to be reviewed by a SFGH medical staff member who either maintains Strain-Counterstrain privileges or is a Doctor of Osteopathy who has received training in the Strain-Counterstrain technique.

REAPPOINTMENT: Review of five 5 cases.

14.80 ADDICTION MEDICINE ___
Provide addiction medicine consultative services and treatment to patients in the inpatient and ambulatory settings.

PREREQUISITES: Currently board admissible, certified, or re-certified by the American Board of Addiction Medicine OR by the American Board of Preventative Medicine Addiction Medicine Subspecialty and board admissible, certified or re-certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty, American Board of Family Medicine, American Board of Pediatrics, American Board of Psychiatry and Neurology, or American Board of Emergency Medicine. Approval of the Director of the Addiction Medicine Service required for all applicants.

PROCTORING: Review of 5 cases. Review to be performed by Addiction Medicine Service Director or designee.

REAPPOINTMENT: Review of 3 cases. Review to be performed by Addiction Medicine Service Director or designee.

____

Addiction Medicine Director/Designee Date

90.00 CTSI (CLINICAL AND TRANSLATIONAL SCIENCE INSTITUTE) - CLINICAL RESEARCH ___
Admit and follow adult patients for the purposes of clinical investigation in the inpatient and ambulatory CTSI Clinical Research Center settings.

PREREQUISITES: Currently Board Admissible, Certified, or Re-Certified by one of the boards of the American Board of Medical Specialties. Approval of the Director of the CTSI (below) is required for all applicants.

PROCTORING: All OPPE metrics acceptable

REAPPOINTMENT: All OPPE metrics acceptable

____

CTSI Medical Director Date

I hereby request clinical privileges as indicated above.

____

Applicant Date

APPROVED BY

Division Chief Date

Service Chief Date

Privileges for Zuckerberg San Francisco General Hospital and Trauma Center

FCM FAMILY AND COMMUNITY MEDICINE 2008
(10/08 MEC) (03/11 Admin. Rev.) (10/21 MEC)

FOR ALL PRIVILEGES: All complication rates, including problem transfusions, deaths, unusual occurrence reports and sentinel events, as well as department quality indicators, will be monitored semiannually.

Applicant ______________________________

Requested Approved

_____ _____ **14.00 OUTPATIENT CARE PRIVILEGES**

_____ _____ **14.01 Ambulatory Care Privileges for Family Medicine prepared physicians**
Perform basic procedures within the usual and customary scope of Family Medicine, including but not limited to diagnosis, management, treatment, preventive care, and minor procedures for patients of all ages in the Family Health Center (FHC), FHC satellites, or the patient's home. All procedures requiring anesthesia to be performed under local anesthesia. May refer patients for admission to the appropriate Inpatient Service, and may write informational notes in the ZSFG inpatient medical record.
Prerequisite: Currently admissible, certified, or recertified by the American Board of Family Medicine.
Proctoring: Review of 5 cases.
Reappointment: Review of 3 cases.

_____ _____ **14.02 Ambulatory Care Privileges for Internal Medicine or Emergency Medicine prepared physicians**
Perform basic procedures within the usual and customary scope of Internal Medicine or Emergency Medicine, including but not limited to diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the Family Health Center (FHC), FHC satellites or the patient's home. All procedures requiring anesthesia to be performed under local anesthesia. May refer patients for admission to the appropriate Inpatient Service and may write informational notes in the ZSFG inpatient medical record.
Prerequisite: Currently admissible, certified, or recertified by the American Board of Internal Medicine or the American Board of Emergency Medicine.
Proctoring: Review of 5 cases.
Reappointment: Review of 3 cases.

_____ _____ **14.03 Behavioral Health Center Privileges**
Performs basic procedures within the usual and customary scope of Family Medicine or Internal Medicine, including but not limited to diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the Behavioral Health Center.
Prerequisite: Currently admissible, certified, or recertified by the American Board of Family Medicine or the American Board of Internal Medicine.
Proctoring: Review of 5 cases.
Reappointment: Review of 3 cases.

Concurrence of Behavioral Health Center Medical Director required.

____
Signature, Behavioral Health Center Medical Director

Privileges for Zuckerberg San Francisco General Hospital and Trauma Center

Applicant

Requested Approved

______ ______ **14.10 INPATIENT CARE PRIVILEGES**

Admit and be responsible for hospitalized adults. Admissions may include medical, surgical, gynecological, and neurological problems, and medical complications in pregnant patients with obstetric consultation. May also follow patients admitted to critical care units in a consultative capacity.

______ ______ **14.11 Family Medicine Inpatient Service Privileges**

Perform basic procedures within the usual and customary scope of Family Medicine, including but not limited to diagnosis, management, treatment, preventive care, and minor procedures for hospitalized adults.
Prerequisite: Currently admissible, certified, or recertified by the American Board of Family Medicine.
Proctoring: Review of 5 cases.
Reappointment: Review of 3 cases.

______ ______ **14.12 Skilled Nursing Facility Care Privileges**

Perform basic procedures within the usual and customary scope of Family Medicine or Internal Medicine, including but not limited to diagnosis, management, treatment, preventive care, and minor procedures for adult patients in the ZSFG Skilled Nursing Facility (SNF).
Prerequisite: Currently admissible, certified, or recertified by the American Board of Family Medicine or the American Board of Internal Medicine.
Proctoring: Review of 5 cases.
Reappointment: Review of 3 cases.

Concurrence of Skilled Nursing Facility Medical required.

____
Signature, Skilled Nursing Facility Medical Director

______ ______ **14.13 Nursery Privileges**

Render care to well newborns, including admitting and performing routine evaluations and management.
Prerequisite: Currently admissible, certified, or recertified by the American Board of Family Medicine.
Proctoring: Case review for 3 newborn admissions.
Reappointment: Case review of 2 newborn admissions.

______ ______ **14.20 PERINATAL PRIVILEGES**

Render care to women during the perinatal period, including specific privileges 14.21 – 14.27, if requested and approved below.

______ ______ **14.21 Normal Vaginal Delivery**

Privileges for Zuckerberg San Francisco General Hospital and Trauma Center

Applicant

_____ _____

Including administration of local anesthesia, performance of episiotomy, and repair of lacerations other than those involving the rectal sphincter.
Prerequisite: Currently admissible, certified, or recertified by the American Board of Family Medicine.
Proctoring: Case review and direct observation of a minimum of 3 deliveries.
Reappointment: Review of 3 cases.

Requested Approved

_____ _____

14.22 Vacuum-assisted Delivery (Obstetrics Consultation Required)
Prerequisite: Currently admissible, certified, or recertified by the American Board of Family Medicine.
Proctoring: For applicants with documentation of prior successful performance of a minimum of 25 vacuum-assisted deliveries: case review and direct observation of a minimum of 2 deliveries using vacuum assistance. For applicants with documentation of fewer than 25 vacuum-assisted deliveries: case review and direct observation of 5 deliveries using vacuum assistance.
Reappointment: Case review of 1 delivery using vacuum assistance.

Concurrence of the Obstetrics and Gynecology Service Chief required.

____

Signature, Obstetrics and Gynecology Service Chief

_____ _____

14.23 First Assist in Cesarean Delivery (Obstetrics Consultation Required)
Prerequisites: Currently admissible, certified, or recertified by the American Board of Family Medicine and documentation of prior successful performance of a minimum of 25 Cesarean deliveries.
Proctoring: Case review and direct observation of 5 Cesarean deliveries.
Reappointment: Case review of 1 Cesarean delivery.

Concurrence of the Obstetrics and Gynecology Service Chief required.

____

Signature, Obstetrics and Gynecology Service Chief

_____ _____

14.24 Ultrasound in Pregnancy
Limited to determination of fetal gestational age, confirmation of presentation, placenta location, amniotic fluid adequacy, and confirmation of fetal heart rate.
Prerequisites: Currently admissible, certified, or recertified by the American Board of Family Medicine and documentation of a minimum of 8 hours instruction and didactic training in ultrasound technology and imaging.
Proctoring: For applicants with documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution (Residency or Medical Staff): case review and direct observation of 5 ultrasounds in pregnancy. For applicants without documentation: case review and direct observation of 25 ultrasounds in pregnancy.
Reappointment: Case review of 2 ultrasound images.

Privileges for Zuckerberg San Francisco General Hospital and Trauma Center

Applicant

______ ______ **14.25 External Cephalic Version**

Prerequisites: Currently admissible, certified, or recertified by the American Board of Family Medicine; active FCM Cesarean delivery privileges; and documentation of a minimum of 2 procedures.
Proctoring: Concurrent review of 2 cases.
Reappointment: Case reviews done in accordance with Obstetrics and Gynecology department quality improvement process.

Concurrence of the Obstetrics and Gynecology Service Chief required.

____
Signature, Obstetrics and Gynecology Service Chief

______ ______ **14.26 Cesarean Delivery**

Prerequisites: Currently admissible, certified, or recertified by the American Board of Family Medicine; completion of 12 month fellowship including training in operative obstetrics; and documentation of a minimum of 50 Cesarean deliveries or active Cesarean delivery privileges within the last 5 years.
Proctoring: Concurrent review of 5 Cesarean deliveries.
Reappointment: Satisfactory performance of a minimum of 10 Cesarean deliveries in 2 years; case reviews done in accordance with Obstetrics and Gynecology department quality improvement process.

Concurrence of the Obstetrics and Gynecology Service Chief required.

____
Signature, Obstetrics and Gynecology Service Chief

______ ______ **14.27 Postpartum Sterilization**

Prerequisites: Currently admissible, certified, or recertified by the American Board of Family Medicine; and documentation of a minimum of 10 procedures within the last 2 years.
Proctoring: Concurrent review of 2 cases.
Reappointment: Case reviews done in accordance with Obstetrics and Gynecology department quality improvement process.

Concurrence of the Obstetrics and Gynecology Service Chief required.

____
Signature, Obstetrics and Gynecology Service Chief

______ ______ **14.30 SPECIAL PRIVILEGES**

Physicians may apply for each of the following procedural privileges separately based on qualifications and scope of practice.

______ ______ **14.31 Lumbar Puncture**

Prerequisite: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).
Proctoring: Review of 2 cases, one of which may be performed on a simulated model.

Privileges for Zuckerberg San Francisco General Hospital and Trauma Center

Applicant

______ ______ **Reappointment:** Review of 2 cases, one of which may be performed on a simulated model.

Requested Approved

______ ______ **14.32 Paracentesis**

Prerequisite: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).
Proctoring: Review of 2 cases, one of which may be performed on a simulated model.
Reappointment: Review of 2 cases, one of which may be performed on a simulated model.

______ ______ **14.33 Thoracentesis**

Prerequisite: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).
Proctoring: Review of 2 cases, one of which may be performed on a simulated model.
Reappointment: Review of 2 cases, one of which may be performed on a simulated model.

______ ______ **14.34 Placement of Central Venous Catheter, including Femoral Venous Catheter**

Prerequisite: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).
Proctoring: Review of 2 cases, one of which may be performed on a simulated model.
Reappointment: Review of 2 cases, one of which may be performed on a simulated model.

______ ______ **14.35 Intrauterine Procedures**

a. Endometrial Biopsy
b. Insertion of Intrauterine Device (IUD)

Prerequisite: Physicians must have FCM Basic Privileges (14.00), Inpatient Care Privileges (14.10), Skilled Nursing Facility (14.12), or Limited Privileges (14.40).
Proctoring: Review of 2 cases.
Reappointment: Review of 2 cases.

______ ______ **14.36 Surgical Termination of First-trimester Intrauterine Pregnancy**

Perform surgical abortions in the first trimester of pregnancy at appropriate facilities at ZSFG.
Prerequisites: Currently admissible, certified, or recertified by the American Board of Family Medicine; completion of at least 20 hours of formal training in surgical abortion, including first-trimester ultrasound for confirmation of intrauterine pregnancy and determination of gestational age, during residency or a CME program; and documentation of 50 procedures.
Proctoring: Case review of 3 surgical terminations.
Reappointment: Case review of 2 terminations.

______ ______ **14.37 Vasectomy**

Prerequisites: Currently admissible, certified, or recertified by the American Board of Family Medicine and completion, as a licensed physician, of a minimum of 20 vasectomy procedures under supervision of a privileged and board-certified Urologist or Family Physician.
Proctoring: Review of 5 cases.
Reappointment: Review of 3 cases.

Privileges for Zuckerberg San Francisco General Hospital and Trauma Center

Applicant

Requested Approved

_____ _____ **14.40 LIMITED AMBULATORY CARE PRIVILEGES**

_____ _____ **14.41 Acupuncture**

Perform acupuncture, acupressure, and moxibustion in the Family Medicine Inpatient Service, Family Health Center (FHC), Skilled Nursing Facility, FHC satellites, and in the patient's home.
Prerequisites: Successful completion, by a licensed physician of at least 200 hours of instruction and didactic training given by a University of California institution or other nationally recognized university.
Proctoring: 5 direct observations and 5 cases to be reviewed by a medical staff member who maintains unproctored status for Acupuncture Privileges within the DPH/ZSFG system. Direct observations and chart reviews may be on the same patient or on different patients. A summary monitoring report will be sent to the respective clinical service to be forwarded to the appropriate committees for privileging recommendation.
Reappointment: Review of 5 cases by a medical staff member who maintains unproctored status for Acupuncture Privileges within the DPH/ZSFG system. A summary monitoring report will be sent to the respective clinical service to be forwarded to the appropriate committees for reappointment recommendation.

_____ _____ **14.42 Dentistry**

Provide professional dental services to hospital and clinic patients; instruct patients in correct oral hygiene and dental care; treat mouth diseases; refer cases requiring oral surgery and medical attention to proper department.
Prerequisites: Completion of the curriculum of an approved school of dentistry and possession of the DDS degree and possession of a valid license to practice dentistry issued by the California State Board of Dental Examiners.
Proctoring: Review of 5 cases.
Reappointment: Review of 3 cases.

_____ _____ **14.43 Clinical Psychology**

Provide individual and family counseling and therapy.
Prerequisites: Possession of a doctoral degree in psychology from an approved APA-accredited program and a license on the basis of the doctorate degree in psychology by the State of California, Board of Psychology.
Proctoring: Review of 5 cases.
Reappointment: Review of 3 cases.

_____ _____ **14.44 Allergy and Immunology**

Work up, diagnose, consult, treat, and interpret clinical findings of adult and pediatric patients in the ambulatory setting with allergy or immunologic diseases. Core privileges include allergy skin testing and interpretation.
Prerequisites: Currently admissible, certified, or recertified by the American Board of Pediatrics or American Board of Internal Medicine and the American Board of Allergy and Immunology or special dispensation from the chief of service for equivalent training.
Proctoring: Review of 5 cases.
Reappointment: Review of 3 cases

Privileges for Zuckerberg San Francisco General Hospital and Trauma Center

Applicant

Requested Approved

_____ _____ **14.50 WAIVED TESTING**

Privileges in this category relate to common tests that do not involve an instrument and are typically performed by providers at the bedside or point of care. By obtaining and maintaining waived testing privileges, providers satisfy competency expectations for waived testing by The Joint Commission.

_____ _____ a. Fecal Occult Blood Testing (Hemoccult®)

_____ _____ b. Vaginal pH Testing (pH Paper)

_____ _____ c. Urine Chemistrip® Testing

_____ _____ d. Urine Pregnancy Test (SP® Brand Rapid Test)

Prerequisites: Currently admissible, certified, or recertified by an American Board in Emergency Medicine, Family Community Medicine, Medicine, Pediatrics, Obstetrics and Gynecology, or General Surgery.
Proctoring: By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.
Reappointment: Renewal of privileges requires every two years documentation of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.

_____ _____ **14.60 STRAIN-COUNTERSTRAIN MANIPULATIVE MEDICINE PRIVILEGES**

Perform manipulation principally for the purpose of relief of primarily muscular pain on the Family Medicine Inpatient Service, Family Health Center (FHC), Skilled Nursing Facility, FHC satellites, and in the patient's home.
Prerequisites: Successful completion, by a licensed physician, of at least 30 hours of instruction and didactic training designed for health care professionals and authorized to provide CME or CE credits. In addition, 5 hours of supervised clinical practice, either during or after residency or completion of training in a Doctor of Osteopathy training program.
Proctoring: 5 direct observations and 5 cases to be0 reviewed by a ZSFG medical staff member who either maintains strain-counterstrain privileges or is a Doctor of Osteopathy who has received training in the strain-counterstrain technique.
Reappointment: Review of five 5 cases.

_____ _____ **14.70 CLINICAL AND TRANSLATION SCIENCE INSTITUTE (CTSI) RESEARCH**

Admit and follow adult patients for the purposes of clinical investigation in the inpatient and ambulatory CTSI Clinical Research Center settings.
Prerequisites: Currently admissible, certified, or recertified by one of the boards of the American Board of Medical Specialties.
Proctoring: All Ongoing Professional Practice Evaluation (OPPE) metrics acceptable.
Reappointment: All OPPE metrics acceptable.

Concurrence of the CTSI Director required.

____

Signature, CTSI Director

Privileges for Zuckerberg San Francisco General Hospital and Trauma Center

Applicant

Requested Approved

______ ______ **14.80 ADDICTION MEDICINE**

Provide addiction medicine consultative services and treatment to patients in the inpatient and ambulatory settings.

Prerequisites: Currently board admissible, certified, or re-certified by the American Board of Addiction Medicine OR by the American Board of Preventative Medicine Addiction Medicine Subspecialty and board admissible, certified or re-certified by the American Board of Internal Medicine, an Internal Medicine Subspecialty, American Board of Family Medicine, American Board of Pediatrics, American Board of Psychiatry and Neurology, or American Board of Emergency Medicine. Approval of the Director of the Addiction Medicine Service required for all applicants.

Proctoring: Review of 5 cases. Review to be performed by Addiction Medicine Service Director or designee.

Reappointment: Review of 3 cases. Review to be performed by Addiction Medicine Service Director or designee.

~~***Concurrence of the Addiction Medicine Service Director or Designee required***~~.

Signature, Addiction Medicine Service Director or Designee

SIGNATURES

, MD	Date	Teresa J. Villela, MD, Chief of Service	Date

Privileges for Zuckerberg San Francisco General Hospital and Trauma Center

Applicant:

APPENDIX: Privileging Criteria Detail

PRIVILEGES	INITIAL PROCTORING CRITERIA	REAPPOINTMENT CRITERIA (every 2 years)
14.00 Outpatient Clinic		
14.01 Ambulatory Care Privileges for Family Medicine prepared physicians	Review of 5 cases	Review of 3 cases
14.02 Ambulatory Care Privileges for Internal Medicine or Emergency Medicine prepared physicians	Review of 5 cases	Review of 3 cases
14.03 Behavioral Health Center Privileges	Review of 5 cases	Review of 3 cases
14.10 Inpatient Care		
14.11 Family Medicine Inpatient Service Privileges	Review of 5 cases	Review of 3 cases
14.12 Skilled Nursing Facility Care Privileges	Review of 5 cases	Review of 3 cases
14.13 Nursery Privileges	Case review of 3 newborn admissions	Case review of 2 newborn admissions
14.20 Perinatal Care		
14.21 Normal Vaginal Delivery	Case review and direct observation of a minimum of 3 deliveries	Review of 3 cases
14.22 Vacuum Assisted Deliveries (OB consultation required)	For applicants with documentation of prior successful performance of a minimum of 25 vacuum assisted deliveries—case review and direct observation of a minimum of 2 deliveries using vacuum assistance. For applicants with documentation of fewer than 25 vacuum-assisted deliveries—case review and direct observation of 5 deliveries using vacuum assistance.	Case review of 1 delivery using vacuum assistance
14.23 First Assist in Cesarean Section (OB consultation required)	Case review and direct observation of 5 Cesarean Section	Case review of 1 Cesarean Section
14.24 Ultrasound in Pregnancy	For applicants with documentation of satisfactory performance of at least 25 ultrasounds in pregnancy at another institution (residency or medical staff): case review and direct observation of 5 ultrasounds in pregnancy. For applicants without documentation: case review and direct observation of 25 ultrasounds in pregnancy.	Case review of 2 ultrasound images
14.30 Special Privileges		
14.31 Lumbar Puncture	Review of 2 cases	Review of 2 cases
14.32Paracentesis	Review of 2 cases	Review of 2 cases
14.33 Thoracentesis	Review of 2 cases	Review of 2 cases
14.34 Placement of central venous catheter, including femoral venous catheter	Review of 2 cases	Review of 2 cases
14.35 Intrauterine Procedure: a) endometrial biopsy; b) insertion of intrauterine device (IUD)	Review of 2 cases	Review of 2 cases
14.36 Surgical termination of first trimester of pregnancy at appropriate facilities	Case of review of 3 surgical terminations	Case review of 2 terminations
14.37 Vasectomy	Review of 5 cases	Review of 3 cases
14.40 Limited Ambulatory Care Privileges		
14.41 Acupuncture	5 direct observations and 5 cases to be reviewed by a medical staff member who maintains unproctored status for acupuncture privileges within the CHN/ZSFG system. Direct observations and chart reviews may be on the same patient or on different patients. A summary monitoring report will be sent to the respective clinical service to be forwarded to the appropriate committee recommendations.	Review 5 cases by a medical staff member who maintains unproctored status for acupuncture privileges within the CHN/ZSFG system. A summary monitoring report will be sent to the respective clinical service to be forwarded to the appropriate committees for reappointment recommendations
14.42 Dentistry	Review of 5 cases	Review of 3 cases
14.43 Clinical Psychology	Review of 5 cases	Review of 3 cases
14.44 Allergy and Immunology	Review of 5 cases	Review of 3 cases

Privileges for Zuckerberg San Francisco General Hospital and Trauma Center

Applicant

PRIVILEGES	INITIAL PROCTORING CRITERIA	REAPPOINTMENT CRITERIA (every 2 years)
14.50 Waived Testing		
14.50 Waived Testing: a) fecal occult blood; b) vaginal pH testing; c) urine pregnancy; d) urine dipstick	By the Chief of the Laboratory Medicine Service or designee until successful completion of a web-based competency assessment tool is documented for each requested waived testing privilege.	Renewal of privileges requires documentation, every two years, of successful completion of a web-based competency assessment tool for each waived testing privilege for which renewal is requested.
14.60 Strain-Counterstain manipulative medicine		
14.60 Strain-Counterstain manipulative medicine	5 direct observations and 5 cases to be reviewed by a SFGH medical staff member who either maintains Strain-Counterstrain privileges or is a Doctor of Osteopathy who has received training in the Strain-Counterstrain technique.	Review of 5 cases
14.80 Addiction Medicine		
14.80 Addiction Medicine	Review of 5 cases. Review to be performed by Addiction Medicine Service Director or designee.	Review of 3 cases. Review to be performed by Addiction Medicine Service Director or designee.

APPENDIX FG: CHART REVIEW FORMS

ZSFG Family and Community Medicine

CHART REVIEW

Appt/Reappt

Provider	Site	Appt Type	Reviewer	Signature	Date

MRN																				
Encounter Date																				
	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA
History, exam, and diagnostic studies reflect patient's condition and reason for visit or admission																				
Assessment and problem identification are accurate and complete																				
Therapeutic plans/regimens meet accepted standards																				
Psychosocial factors are noted and included in development of therapeutic plans																				
Problem list is reviewed and updated																				
Medication list is reviewed and updated																				
Allergies are reviewed and updated when needed																				
Health care maintenance is reviewed and updated when needed																				
Patient education is documented																				
IF SUPERVISING TRAINEES: Note reflects expected level of involvement in care of patient																				

Comments

Corrective Action None Needed Provider Counseled Topic Discussed in Staff Mtg Other:

Use this form for Privileges 14.01, 14.02, 14.03, 14..11, 14.12, 14.13, 14.41
March 2022

SFGH Family and Community Medicine

PROCEDURE REVIEW
CLINICAL PRACTICE

Provider	Service	Init/Reappt Appt Type	Reviewer	Signature	Date

Procedure																				
MRN																				
Encounter Date																				
	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA
Indication for procedure is documented, including history and exam																				
Informed consent obtained in the patient's language																				
"Time-out" procedure completed and documented																				
Procedure performed/supervised with satisfactory technical skill																				
Post-procedure education and management																				
Management of complications (if any)																				

Comments

Corrective Action   None Needed   Provider Counseled   Topic Discussed in Staff Mtg   Other:

Use this form for Privileges 14.21,14.22, 14.23, 14.24,14.25, 14.26, 14.27, 14.31, 14.32, 14.33, 14.34, 14.35, 14.36, 14.37, 14.41, 14.60
March 2022

SFGH Family and Community Medicine

CHART REVIEW—PSYCHOLOGY CARE

CLINICAL PRACTICE

Provider	Clinic	**Init/Reappt** Appt Type	Reviewer	Signature	Date

	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA	Acceptable	Improve	Unacceptable	NA
MRN																				
Encounter Date																				
Statement of patient's view of problem																				
Important interpersonal relationship noted.																				
Assessment of patient's problem in context of relationship.																				
Therapeutic plan noted.																				
Progress of therapeutic plan noted.																				
Overall care meets high standards.																				

Comments

Corrective Action None Needed Provider Counseled Topic Discussed in Staff Mtg Other:

Use this form for Privilege 14.43
March 2022

APPENDIX G~~H~~: OPPE FORM AND THRESHOLDS

	FCM OPPE 2020; updated 2024				
		Acceptable	Marginal	Unacceptable	*DATA Source*
Patient Care					
	1. SBP <150 for patients diagnosed with HTN	≥ 60%	51-59%	≤ 50%	Epic unedited
	2. Percent of Patient Panel Aged 45-75 With Up To Date Colorectal Cancer Screening	≥ 40%	25-39%	≤ 24%	Epic unedited
	3. Procedure Complications Attributable to Provider	0-1	2	≥ 3	Department Review
Medical/Clinical Knowledge					
	4. CME Activity Within Past Year	≥ 50 hours	n/a	< 50 hours	Department Review
Practice Based Learning and Improvement					
	5. Completion of ZSFG Required Annual Hospital Training Modules	Current	n/a	Not current	Medical Staff Office (MSO)
	6. Participation in Maintenance of Board Certification Activities	Current	n/a	Not current	Department Review
Interpersonal and Communication Skills					
	7. Cases of Concern/Patient Complaints/SAFE Reports/Sentinel Events	<2	2	>2	Department Review
	8. Cases of Concern/Colleague, Staff, Trainee Complaints/SAFE Reports/Sentinel Events	<2	2	>2	Department Review
Professionalism					
	9. Attendance at Monthly Department Clinical Meetings	≥ 60%	41-59%	≤ 40%	Department Review
	10. Cases of Concern/Staff Concerns/SAFE Reports/Sentinel Events	<2	2	>2	Department Review
Systems Based Practice					
	11. Primary Care: Patient Panel Size	≥ 80% of target	70-79% of target	≤ 69% of target	Epic unedited
	12. Percentage of All Attributable Notes Closed in 3 days	> 90%	80-89%	< 80%	Epic data entered by MSO

DATA SOURCES
Epic
Department Review
Medical Staff Office (MSO)

	FCM OPPE 2020						
		Acceptable	Marginal	Unacceptable	Not Relevant	Comments	*DATA Source*
Patient Care							
	1. SBP <150 for patients diagnosed with HTN	≥ 60%	51-59%	≤ 50%			Epic unedited
	2. Percent of patient panel aged 50-75 with up to date colorectal cancer screening	≥ 40%	25-39%	≤ 24%			Epic unedited
	3. Procedure complications attributable to provider	0-1	2	≥ 3			Department Review
Medical/Clinical Knowledge							
	4. Board certification	Active/Current	<2 years overdue	≥ 2 years overdue			MSO (Halogen reports, board cert, license)
	5. CME activity within past year	≥ 50 hours	31-49 hours	≤ 30 hours			Department Review
Practice Based Learning and Improvement							
	6. Completion of annual required ZSFG training modules	Prior to deadline	Within 60 days of deadline	≥ 60 days delayed			MSO (Halogen reports, board cert, license)
	7. Participation in maintenance of Board certification activities	Current	n/a	Not current			Department Review
Interpersonal and Communication Skills							
	8. Cases of concern/patient complaints/UOs/sentinel events	<2	2	>2			Department Review
	9. Cases of concern/Colleague, Staff, Trainee complaints/UOs/sentinel events	<2	2	>2			Department Review
Professionalism							
	10. Attendance at monthly department clinical meetings	≥ 60%	41-59%	≤ 40%			Department Review
	11. Cases of concern/staff concerns/UOs/sentinel events	<2	2	>2			Department Review
Systems Based Practice							
	12. Primary Care: patient panel size	≥ 80% of target	70-79% of target	≤ 69% of target			Epic unedited
	13. Outpatient, Inpatient and SNF: Completing discharge summaries and closing notes within 72 hours	> 90%	80-89%	< 80%			Epic unedited

DATA SOURCES
Epic unedited
Department Review
MSO (Halogen reports, board cert, license)

☐ 8.11 NP 103 Basic Privileges - Adult

- Provides medical care to adults (18 years of age or older) with primary medical problems, provides preventive care, and performs minor treatment procedures in the OUTPATIENT GROUP SETTING.

Initial Criteria

CA BRN NP 103 licensure (*as required by the CA BRN*), *who has been practicing as a nurse practitioner in direct patient care for a minimum of three full-time equivalent years or 4,600 hours within the last five years, which includes adult* primary care experience)

Proctoring Criteria

For providers whose NP 103 licensure eligibility is based on the majority of their full-time 103 experience performed at CPC, requirement of 3 chart reviews of CPC adult primary care patients. OR For providers whose NP 103 licensure eligibility is not based on the majority of their full-time 103 experience performed at CPC, consecutive, concurrent observation and chart review of 3 adult patients (must include 1 new adult patient to CPC primary care),

Reappointment Criteria

Chart review of 3 cases (over 2-year reappointment period)

☐ 8.21 NP 103 Basic Privileges - Pediatric

- Provides medical care to children and transitional youth (0 to 24 years of age) with primary medical problems, provides preventive care, and performs minor treatment procedures in the OUTPATIENT GROUP SETTING.

Initial Criteria

CA BRN NP 103 licensure (*who has been practicing as a nurse practitioner in direct patient care for a minimum of three full-time equivalent years or 4,600 hours within the last five years, which includes patients 0 - 24 years of age*)

Proctoring Criteria

For providers whose NP 103 licensure eligibility is based on the majority of their full-time 103 experience performed at CPC including pediatric patients, requirement of 3 chart reviews of CPC pediatric primary care patients. OR For providers whose NP 103 licensure eligibility is not based on the majority of their full-time 103 experience performed at CPC including pediatric patients, consecutive, concurrent observation and chart review of 3 pediatric patients (must include 1 new pediatric patient to CPC primary care),

Reappointment Criteria

DRAFT

Chart review of 3 cases (over 2-year reappointment period)

☐ 8.31 NP 103 Basic Privileges - Perinatal

- Provides prenatal medical care to pregnant patients and pre- and postpartum care in the OUTPATIENT GROUP SETTING. Clinical care is rendered in accordance with protocols of the CPC service, all procedures requiring anesthesia to be performed under local anesthesia.

Initial Criteria

CA BRN NP 103 licensure, Family Nurse Practitioner: Family/individual across Lifespan, OR Women's Health Gender (*who has been practicing as a nurse practitioner in direct patient care for a minimum of three full-time equivalent years or 4,600 hours within the last five years, that includes perinatal healthcare*)

Proctoring Criteria

For providers whose NP 103 licensure eligibility is based on the majority of their full-time 103 experience performed at CPC including perinatal patients, requirement of 3 chart reviews of CPC perinatal care patients. OR For providers whose NP 103 licensure eligibility is not based on the majority of their full-time 103 experience performed at CPC including perinatal patients, consecutive, concurrent observation and chart review of 3 perinatal patients (must include 1 new perinatal patient to CPC primary care),

Reappointment Criteria

Chart review of 3 cases (over 2-year reappointment period)

☐ 8.41 NP 103 *Limited Privilege* – Reproductive Health

- Perform family planning, preconception counseling, STD prevention, IPV prevention, and other outpatient management related to sexual health, excluding pregnancy, for patients aged 12-24 in the OUTPATIENT GROUP SETTING.
- *No need to apply for this if privileged in 8.11 NP 103 Basic Privileges - Adult or 8.21 NP 103 Basic Privileges - Pediatric as this privilege falls within their scope.*

Initial Criteria

CA BRN NP 103 licensure, Women's Health Nurse Practitioner (*who has been practicing as a nurse practitioner in direct patient care for a minimum of three full-time equivalent years or 4,600 hours within the last five years, that includes reproductive healthcare*)

Proctoring Criteria

For providers whose NP 103 licensure eligibility is based on the majority of their full-time 103 experience performed at CPC including reproductive health patients, requirement of 3 chart reviews of CPC reproductive health care patients.

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OR For providers whose NP 103 licensure eligibility is not based on the majority of their full-time 103 experience performed at CPC including reproductive health patients, consecutive, concurrent observation and chart review of 3 reproductive health patients (must include 1 new reproductive health patient to CPC primary care),

Reappointment Criteria

Chart review of 3 cases (over 2-year reappointment period)

Community Primary Care
NP 103 Privileges
Special Privileges - Standard

Pre-Requisite (Initial Criteria)

Documentation of 5 cases within last 24 months (outside ZSFG, *may include an attestation that includes sign off from supervisor [current or former]*)

Proctoring (FPPE) Criteria

NPs who do not meet the above pre-requisite

Phase 1 - Verification of on-site training completion, including department-specific education, observation, and supervised practice (didactic & observation)

AND

Phase 2 - Completion of two (2) encounters independently without immediate complication, under direct observation. If previously proctored under SP protocol within CPC; chart review is required, direct observation not required.

NPs who meet the above pre-requisite

Phase 2 - Completion of two (2) encounters independently without immediate complication, under direct observation. If previously proctored under SP protocol within CPC; chart review is required, direct observation not required.

Reappointment Criteria

Maintenance of these procedural privileges requires demonstrated competence of at least two (2) procedures with acceptable results within the past 24 months.

	Privileges Requested	Prerequisites Met OR	Training Met	Proctoring Met
Arthrocentesis and Intraarticular Injections	☐	☐	☐	☐
Cryotherapy of warts	☐	☐	☐	☐
Endometrial Biopsy	☐	☐	☐	☐
Fitting Pessaries	☐	☐	☐	☐
Incision and drainage	☐	☐	☐	☐
Incision and Drainage of Skin Abscesses	☐	☐	☐	☐
Insertion of Contraceptive Implant	☐	☐	☐	☐
Insertion of Intrauterine Device	☐	☐	☐	☐
Removal of Contraceptive Implant	☐	☐	☐	☐
Removal of Intrauterine Device	☐	☐	☐	☐
Skin Punch Biopsy	☐	☐	☐	☐
Splinting	☐	☐	☐	☐
Surface Trauma and Wound Care	☐	☐	☐	☐
Tattoo Removal	☐	☐	☐	☐
Trigger point injections	☐	☐	☐	☐
Waived Testing(see page 5)*				

**Unless otherwise specified*

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Pre-Requisite (Initial Criteria)

Clinical Assignment within the Community Primary Care Service and basic privileges as a CPC 103 NP

Proctoring Criteria

Completion of quizzes for each test with a passing score of 80%.

Reappointment Criteria

Completion of quizzes for each test with a passing score of 80%.

	Privileges Requested	Prerequisites Met	Training Met	Proctoring Met
1. Fecal Occult Blood	☐	☐	☐	☐
2. Vaginal Ph Testing	☐	☐	☐	☐
3. Urine Pregnancy	☐	☐	☐	☐
4. Urine Dipstick	☐	☐	☐	☐

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ZSFG Medical Staff Bylaws Revisions Summary of Changes Document

Note: All final submitted revisions were reviewed by the Bylaws Committee, comprised of Medical Staff members, Affiliated Professionals, members of the SFHN Medical Staff Services Department and the San Francisco City Attorneys Office.

Articles: Preamble, 1, 2,
Edited By: Levy, Lifton, Mercer

Summary of Changes:
Preamble:
Edited By: M Mercer G Levy H Lifton

- Definition of terms included here- including roles (titled and untitled), governance structure/responsibilities, precise definition of any mention of days (calendar) and specific terms such as “Clean File”
- Cleaned up definitions including defining attendings
    - *“Attending Faculty or Attending: Member of the Medical Staff who meets the Bylaws board certification or eligibility requirements within their specialty and who supervises (or may supervise) physicians in training (residents or fellows), medical students and affiliated professionals. Attending physicians may also be faculty or volunteer faculty at University of California Sam Francisco School of Medicine.”*
- Clarified functions/roles/ positions of Director of Health in JCC, etc.
- Definition of Clean file and verification was clarified to be the sole determination of Chair of Credentials Committee or designee
- Definition added for “Practitioner” = A member of the Medical Staff or an Affiliated Professional with either Privileges or Standardized Procedures conferred through the medical staff process

Article 1: Name and Purpose
Edited By: M Mercer G Levy H Lifton

- Kept addition from prior Bylaws revision of supporting Equity in the charge of the medical staff functions:
    - “Actively support the Hospital’s commitment to equity in clinical, educational, and workplace relationships and systems.”

Article 2: Medical Staff membership

Edited By: M Mercer G Levy H Lifton

- Added reference to American Osteopathic Association (for alignment of conduct guidelines)
- Highlighted "basic standards of conduct" and will references respective areas in Articles 6&7 re: professional conduct expectations (Section2.2)
    - *"An Applicant must demonstrate compliance with all the basic standards set forth in this Article 2 in order to have an application for Medical Staff membership accepted for review. The Applicant must meet the following standards:"*
- Defined indications and process for granting of Temporary and Permanent waiver of ABMS Certification to maintain privileges (i.e. if not ABMS and no pathway to be able to become-such as if FMG – note section on Credentials/ Reappointment there is no way for MSO to track. So, it is responsibility of individual and Chief of Service to verify ongoing maintenance of certification or equivalent maintenance of skill (Section 2.2.3)
- Professional liability Insurance requirements updated to allow adjustments from $2M and $6M requirement of coverage (i.e. for clinicians such as acupuncturists) (Section 2.2.4)
- Reverted to 2-year reappointment window – instead of 3 yr which was requested due to state regulations still requiring 2 yr. (Section 2.4.2)
- Clarified nondiscrimination terms (Sectiion 2.6)

Article(s): 3 – Categories of the medical staff

Edited By: M Mercer G Levy H Lifton

Summary of Changes:

- No significant changes from 2023 edits
- 2023 edits included:
    - Addition of quality improvement requirements (ie. Peer review, RCA, etc.) for Active, Courtesy and Provisional and Administrative medical staff as follows"
        - *" [Category as above] Medical Staff Members are required to participate in specific quality improvement activities that address their duties or involved them as a participant or witness."*

- Inactive Medical Staff Section – clarification of QI as above as well as on voting privileges
  - *"Inactive Medical Staff Members, when they have inactive status, are not eligible to vote, to hold Medical Staff offices, or to serve on Medical Staff committees. Inactive Medical Staff Members are required to participate in specific quality improvement activities that address their duties or involved them as a participant or witness."*

Article 4: Appointments and Reappointments
Reviewed by: M Mercer, G. Ortiz, G. Levy (counsel), A Gelb, J Frieberg, S Chow, K Myers, J Critchfield, J Evland, G Zarbock (counsel)

Summary of Changes:

- Updated article to clarify that Affiliated Professionals are subject to same appointment processes and standards as medical staff
- Clarified roles and responsibilities of Clinical Service and Med Staff Office in providing Rules and Reg and Bylaws to applicants (4.2.2)
- Clarified timing of review of applicants and recommendation review from MEC to Governing Body
- Clarified roles and responsibilities of the Credentials Committee, MEC, and Governing Body in the review and recommendation process (4.3.4-4.3.6)
- Clarified language re: no full procedural rights if new appointment or new privileges denied (4.2.6)
- Clarified that Affiliated Professionals are subject to the same standards of oversight by the Chief of the Clinical Service as medical staff, including progressive discipline and corrective action (4.7.5)
- Retained wording re: Affiliated Professionals not granted procedural rights (4.7.5)

Article 5: Clinical Privileges

Reviewed by: M Mercer, G. Ortiz, G. Levy (counsel), A Gelb, J Frieberg, S Chow, K Myers, J Critchfield, J Eveland, G Zarbock (counsel)

Summary of Changes:

- Clarified language regarding Affiliated Professional Status and appointment with standardized procedures are subject to the same oversight regarding quality improvement as for Medical Staff with Privileges. (5.1.1)
- Clarified Temporary appointment Processes as well as categories of the Medical Staff including Emergency and Visiting Physicians and clarified process for of Emergency Privileges
- Added Affiliated Professionals and Affiliated Status throughout
- Described basic processes for proctoring following appointment or new privileges

Article 6: Monitoring and Corrective Action

Reviewed by: M Mercer, G. Ortiz, G. Levy (counsel), A Gelb, J Frieberg, S Chow, K Myers, J Critchfield, J Eveland, G Zarbock (counsel), T Villela, J Cuschieri

Summary of Changes:

- Described and clarified the standards of and processes for routine and "issue-related" monitoring (for cause) through the OPPE and FPPE processes. (Section 6.1)
- Clarified that all medical staff and Affiliated Professionals are subject to same professional standards of behavior, and same progressive discipline and/ or corrective action steps (Section 6.2)
- Removed prior clause (6.2.4) which gave Director of Health unilateral authority to restrict access to the health record or campus and in so doing revoked procedural rights (to a hearing). Noted that there are other Rules, Regulations and processes that can restrict access to EHR or campus, and compliance with state regulations ensures procedural rights for medical staff
- Describes reporting requirements (805 report) to state licensing board following types of or duration of suspension (Section 6.5.5)

Article 7: Hearings and Appellate Review
Reviewed by: M Mercer, G. Ortiz, G. Levy (counsel), A Gelb, J Frieberg, S Chow, K Myers, J Critchfield, J Eveland, G Zarbock (counsel), T Villela, J Cuschieri

Summary of Changes:

- Clarified Process components of Corrective Actions taken against Affiliate Professionals (Section 7.2.3)
- Clarified process components of Hearings, including process for requesting a hearing, selection of a Judicial Review Committee, duties of the Committee and of the Hearing officer, Discovery process, Hearing logistics, Voting (Section 7.3 and 7.4)

Article(s): 8-10
Edited By: J Cuschieri, M Mercer G Levy, T Villela

Summary of Changes:

Article 8- Structure of the Medical Staff

Edited By: J Cuschieri, M Mercer G Levy, T Villela

- Lists officers of Medical Staff (COS, COS Past and Elect, MEC);
- Describes election process
- Updates term of service for Chief of staff as two years; Changes option to re-elect to 1 year additional term rather than full term for re-election (current state in 2022 bylaws)

Article 9- Clinical Services:
Edited By: J Cuschieri, M Mercer G Levy, T Villela

Changes from 2022 and 2023:

- Defines Clinical Services and Describes roles and responsibilities of Chiefs of service
- New- Clarifies role of Chief of Staff and timing of nominations relative to position negotiations at UCSF Dept and Vice Deans office level

- New- Described Vacancy process for UCSF Chief of Service- and delineated role of UCSF Dept of Chair and Vice Dean's office for extending offer and negotiations with consultation of Chief of Staff and Hospital Administration
- New- Clarified Process for Chief of Service Selection (need to verify with updated SW document); Added "At least one Affiliated Professional' to search committee for Chief of service"
- New - Add role of Vice Dean's office in overseeing review and reappointment process for chief of service every 5 years
- New- Clarifies CPC vacancy and appointment process in consultation with Director of Health

Article 10 – Physician leadership
Edited By: J Cuschieri, M Mercer G Levy, T Villela

- No major changes from 2023 or current
- Describes "physician leadership" and defines reporting structures
- New- Adds "Associate CMO" roles in hospital administration pieces

Article(s): 11- Committees of the Medical Staff

Edited By: Mercer, Levy, Chow

Summary of Changes:

- Updated List of Committees and their reporting frequency based on feedback from committee chairs or others
  - Infection Control, Utilization Mgmt, Wellbeing – all moved to twice yearly rather than quarterly
  - Lab Committee stays quarterly as it is restarting
  - Pharmacy stays monthly
  - Code Blue as subcommittee of pips requested to report annually
- MEC Committee Membership and voting clarified
  - Added Chief of Performance Excellence as Voting member
  - Added Affiliated Professional to At Large group (voting)
  - Described non-voting members of MEC and added Non-voting standing members- ACMOs, Chief of Pharmacy etc.
- UM Committee updated per committee request
- TBD other committee updates requested but may defer until 2026-7

Article 12: Meetings of the Entire Medical Staff
Edited By: Levy, Lifton, Mercer

Summary of Changes:

- No significant changes -except discussions for special meeting and definitions of percentage of active staff needed for calling a special meeting or consisting of a quorum for the meeting)
- 12.1 Annual meeting Bi-annual participation expectation (Every 2 years expectation is not stated. In fact, the prior version stated “Each member of the medical staff is expected to attend the annual meeting or any special meeting pursuant to these bylaws.” We have added “at least once every two years…” to that sentence.
- 12.3 Special meetings- May be called within 10d of a written notice “signed by no less than 10% of all Active medical staff.” And Quorum would require minimum of “20 % active medical staff” present (CHA bylaws recommend 25% for quorum)

Article(s): 13 Confidentiality of Information; Immunity & Releases
Edited By: Critchfield, Eveland, Gelb, Levy, Mercer

Summary of Changes:

- Broadened the definition of who this covers involved
- Clarified language around privacy protection for discussions and deliberations
    - FPPEs and conclusion. Of FPPEs are made available to the member/professional about whom it is made

Article(s): 14: Conflicts between the Medical Staff and the Governing Body
Edited By: Critchfield, Eveland, Gelb, Levy, Mercer

Summary of Changes

- Added in Vice Dean into the conflict resolution workflow and clarified CEO and Vice dean do not vote- serve as guides for dispute

Article(s): 15 Rules and Regulations
Edited by Mercer, Levy

Summary of Changes:

- Minor typographical changes
- Take-aways: Rules and Regs are subject to same process for revision as Bylaws; Rules and Regs of Clinical services are reviewed approved by MEC and JCC

Article(s): 16 -Adoption and Amendment
Edited By: Levy, Mercer

Summary of Changes

- No signif change
- Take-away is that timeline for revision would have
  - JCC review first, then go to MEC for vote- we should target April or May for JCC if plan on in-person vote
  - Need 14 day circulation of Bylaws to Med Staff
  - Need 2/3 affirmative vote for Bylaws
  - Could be electronic vote

Article: 17 -Miscellaneous Provisions
Edited By: Levy, Mercer

Summary of Changes:

- Describes requirement for multiple forms of contact including work and personal email and home address
- Describes difference in notice type –Email only is ok except for disciplinary actions which require both email and certified mail
- Additions of requirements to notify MSSD if action is taken, law broken, or if under investigation at any hospital or by any licensing authority

THE PRISCILLA CHAN AND MARK ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER

April 2026

Draft

MEDICAL STAFF BYLAWS

ZSFG Medical Staff Bylaws

PREAMBLE

WHEREAS, The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG or Hospital) is a public hospital organized under the laws of the State of California and the Charter of the City and County of San Francisco; and

WHEREAS, its purpose is to serve as a general hospital providing patient care, research, and undergraduate and postgraduate education in the health sciences; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Governing Body, and that the cooperative efforts of the Medical Staff, the Hospital Administration and the Governing Body are necessary to fulfill the Hospital's obligations to its patients.

THEREFORE, the physicians, dentists, clinical psychologists, and podiatrists practicing in the Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws and Rules and Regulations. These Bylaws and Rules and Regulations provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with Applicants to, and Members of, the Medical Staff as well as with Affiliated Professionals whose clinical care is subject to Medical Staff oversight.

DEFINITIONS

Affiliated Professional: Individuals who are credentialed through the Medical Staff, are subject to general Medical Staff oversight, and belong to a professional category not eligible for Medical Staff Membership. They are not Members of the Medical Staff and are not afforded the due process rights set forth in these Bylaws, and they may not vote on amendments to the Bylaws or Rules and Regulations.

Attending Faculty or Attending: Member of the Medical Staff who meets the Bylaws board certification or eligibility requirements within their specialty and who supervises (or may supervise) physicians in training (residents or fellows), medical students and affiliated professionals (if required by their licensure). Attending physicians may also be faculty or volunteer faculty at University of California School of Medicine.

Applicant: Physician, dentist, podiatrist, or clinical psychologist who is applying for Medical Staff membership. To the extent applicable based on the context listed in these Bylaws, this term also applies in relation to people who are applying to be an Affiliated Professional.

Chief of Service: Each Member of the Active Medical Staff who is selected under Section 9.2 of these Bylaws to lead a Hospital clinical service and perform the duties listed in Section 9.3 of these Bylaws for that service. Each clinical service has a Chief of Service.

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Chief of Staff: The Member of the Medical Staff who is elected as outlined by Article 8 of these Bylaws to serve as an officer of the Medical Staff and who serves as the head of the Medical Staff. The Chief of Staff has the powers and duties listed in Article 8 as well as elsewhere in these Bylaws.

City: The City and County of San Francisco.

Clean Application: An application for membership to the Medical Staff for which there is no missing information, all primary source verifications have been completed, and there are no

issues that raise concerns about the ethics, judgement, or quality of care of the application. The Chair of the Credentials Committee, in the Chair's sole discretion, will make the final determination as to whether the application is clean. Such applications may be approved by an email vote of the Credentials Committee and the Medical Executive Committee. Approval by the Governing Body must occur at a meeting of the Governing Body or a Committee of the Governing Body.

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Clinical Service: A Hospital service group as listed in Article 9 of these Bylaws.

Date of Receipt: The date on which any Notice or other communication that was delivered personally or electronically, or three (3) days after it was postmarked.

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Department Chair: The Chair of the Department at the University of California, San Francisco. For the Community Primary Care Service (CPC), the Director of Primary Care or their designee will act as the "Department Chair".

Deleted: **Days:** Calendar days.

Director of Health: The Director of the San Francisco Department of Public Health, who also serves as a member of the Joint Conference Committee for Quality Assurance for the Hospital. The Director of Health will ensure that information that is required to be communicated to the Governing Body by these Bylaws will be communicated, and such information may be communicated to the Director of Health without jeopardizing any peer review protections.

Deleted: and the individual who serves as the Chief Executive Officer of the Governing Body and, as such, information …

Director of the San Francisco Health Network: The individual responsible for managing the delivery system of the Department of Public Health and who supervises the Hospital's Chief Executive Officer. Information required to be communicated to the Hospital's Chief Executive Officer may be communicated to the Director of the San Francisco Health Network without jeopardizing any peer review protections.

DPH: The San Francisco Department of Public Health.

Governing Body: The San Francisco Health Commission subject to the responsibilities designated to the Director of Health by the San Francisco Charter and Municipal Code.

Hospital: The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center.

Hospital Administration: Executive Staff Committee members, including the Hospital Chief Executive Officer, Senior Associate Administrators, and Associate Administrators appointed by the Director of Health or Hospital Chief Executive Officer, who implement the day-to-day operations of the Hospital.

House Staff: Trainees in Accreditation Council for Graduate Medical Education or American Board of Medical Specialties programs.

Joint Conference Committee for Quality Assurance (JCC): the committee where members of the Governing Body, Hospital Administration and Medical Staff review and discuss the Hospital's credentialing and quality assurance and performance improvement program.

Medical Staff: The organization established by these Bylaws and consisting of the collective group of Members duly appointed under these Bylaws and that takes action on behalf of Members as outlined by these Bylaws.

Medical Staff Services Department (MSSD): The hospital department that administratively supports medical staff activities.

Medical Staff Year: The period from July 1 through June 30.

Member: Physicians, dentists, clinical psychologists, and podiatrists whose applications have been approved by the Medical Executive Committee and the Governing Body for membership on the Medical Staff.

Practitioner: A neutral term used to describe either a Member of the Medical Staff or an Affiliated Professional as defined elsewhere in these Bylaws whose Clinical Privileges and Credentialing are governed by the Medical Staff Bylaws and Rules and Regulations

Notice: A written communication delivered personally, by email, electronically, or sent by United States mail regarding an appointment, reappointment, privileges, or Medical Staff status.

San Francisco Health Network (SFHN): The healthcare delivery system of the San Francisco Health Department. Hospital and community primary care are components of this delivery system that also includes skilled nursing care, mental health, substance abuse, and jail health services.

Staff: All people who work at the Hospital, whether as paid employees or volunteers of the City or UCSF or as contractors, including people who perform clinical, administrative, facility maintenance, or other duties.

University or UCSF: The University of California, San Francisco.

Vice Chair of a Medical Staff Committee: An individual who is subordinate to the Committee Chair and need not be a Member of the Medical Staff. The Vice Chair may chair Committee meetings and may represent the Committee at Medical Executive Committee meetings in the absence of the Chair.

Vice Dean: The UCSF Vice Dean located at the Hospital.

Note 1-Designation of "Acting" Executives – The terms "Chief of Staff," "Chief of Service," "Chief Executive Officer," "Vice Dean," and "Director of Health" include any persons designated to act on each person's behalf.

Note 2-Clarification of time-based definitions – All references to days in these Bylaws are to calendar days (not business days).

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ARTICLE 1. NAME AND PURPOSES

1.1. Name

The name of this organization is the Medical Staff of The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center.

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1.2. Purposes and Responsibilities

The purpose of the Medical Staff is to work with, and alongside, Hospital Administration and Staff to achieve the Hospital's True North (see Appendix 1). Specifically, the Medical Staff's purposes and responsibilities are to:

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1.2.1. Collaborate

Collaborate with Hospital Administration to improve the services provided to patients;

1.2.2. Patient Care

Assure that all patients admitted to or treated in any of the facilities, departments or services of the Hospital receive care at a level of quality and efficiency consistent with generally accepted standards and attainable within the Hospital's means and circumstances;

1.2.3. Professional Performance

Assure a high level of professional performance of all Applicants authorized to practice in the Hospital through the appropriate delineation of the Clinical Privileges that each Applicant may exercise in the Hospital and through a continuing review and evaluation of each Applicant's performance in the Hospital;

1.2.4. Educational Setting

Provide an appropriate educational setting for continuing education of the Medical Staff and Affiliated Professionals and for the education of both undergraduate and graduate students in the health sciences;

1.2.5. Community Health Education

Organize and support community health education and support services;

1.2.6. Self-Governance

Develop and maintain Bylaws for self-governance of the Medical Staff;

1.2.7. Communication

Provide a means whereby issues of mutual concerns to the Medical Staff and Hospital Administration may be discussed by the Medical Staff with the Governing Body, the Chief Executive Officer, and the Director of Health;

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1.2.8. Performance Improvement and Patient Safety

Incorporate the principles of performance improvement and patient safety in the provision of clinical care; and

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1.2.9. Equity

Actively support the Hospital's commitment to equity in clinical, educational, and workplace relationships and systems.

Commented [LG(3]: For committee discussion.

ARTICLE 2. MEDICAL STAFF MEMBERSHIP

2.1. General Qualifications

Membership on the Medical Staff of the Hospital is a privilege that will be extended only to those Applicants who are professionally competent and continuously meet the qualifications, standards and requirements set forth in these Bylaws. Only those currently licensed physicians, dentists, clinical psychologists and podiatrists whose experience, training, ethics and demonstrated competence assure, in the judgment of the Medical Staff and the Governing Body, that any patient treated by them in the Hospital will receive quality medical care, may qualify for membership. Members of the Medical Staff must conduct themselves in the highest ethical tradition and in a manner consistent with the Code of Ethics of the American Medical Association, the American Dental Association, the American Psychological Association, the American Osteopathic Association, or the American Podiatric Medical Association. Individuals in administrative positions who desire Medical Staff membership or clinical privileges are subject to the same procedures as all other Applicants for membership or privileges.

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2.2. Basic Qualifications for Consideration of Application For Active and Courtesy Medical Staff for Initial Appointment or Reappointment

To qualify for initial appointment or reappointment, an Applicant or Member or Affiliated Professional must demonstrate compliance with all the basic standards set forth in this Article 2 in order to have an application for Medical Staff membership accepted for review. The Applicant must meet the following standards:

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2.2.1. Licensure

Physicians must (1) be licensed to practice medicine by the Medical Board of California or Osteopathic Medical Board of California or (2) comply with all of the requirements of California Business and Professions Code Section 2113 or Section 2168 *et seq*., including possession of a valid and current Certificate of Registration under those code sections and approval by the UCSF Dean, School of Medicine and the Vice Dean at the Hospital.

Dentists must be licensed to practice dentistry by the Dental Board of California.

Podiatrists must be licensed to practice podiatry by the California Board of Podiatric Medicine.

Clinical psychologists must be licensed to practice clinical psychology by the California Board of Psychology.

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2.2.2. Drug Enforcement Agency (DEA)

Applicants must possess by their start date a valid federal DEA number unless the Applicant will never prescribe, or supervise the prescribing of, medications.

2.2.3. Physician Board Certification

A. Applicants must be certified or be progressing towards certification by (1) boards that are duly organized and recognized by an American Board of Medical Specialties (ABMS) or (2) a board or association with an Accreditation Council for Graduate Medical Education-approved postgraduate training that provides

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complete training in that specialty or subspecialty. Applicants must become board certified before their first reappointment. In surgical specialties where case requirements must be met after training, exceptions may be made, but all applicants must achieve board certification no later than six years after the initial granting of Medical Staff membership. Re-applicants who have let their board certification lapse must become board certified no later than the second reappointment after their certification lapsed.

B. A Chief of Service may submit a written request for waiver of the certification requirement or an extension of the six-year period to become board certified to the Medical Executive Committee (MEC) for persons who demonstrate that their education, training, experience, ability, judgment, and medical skills make them sufficiently qualified to serve as Medical Staff Members. The MEC and the Governing Body will consider each request and determine whether approval is in the best interest of the patients and of the Hospital.

Persons appointed with an approved waiver as described above must be categorized with one of the following statuses:

1) Temporary Waiver
Temporary waivers are valid for the duration of the appointment or reappointment period. The temporary waiver is intended for people with a path to ABMS certification that is compatible with expectations and scope of their academic role and clinical duties. The person with the waiver is progressing toward certification by a board duly organized and recognized by the ABMS and must address their certification status at application for reappointment as outlined in this subsection 2.2.3.

2) Permanent Waiver
The waiver is permanent and automatically applies to future reappointments. The permanent waiver is intended for foreign trained providers that meet either of the below criteria:

a. Have no reasonably-feasible path to ABMS certification (*i.e.*, no path at all or a path to board certification that is either highly restrictive or would place undue burden on the individual and/or Clinical Service, significantly distracting from the Applicant's primary duties).

b. Are practicing medicine with the approval of the Medical Board of California pursuant to Section 2168 of the California Business and Professions Code.

2.2.4. Professional Liability Insurance

Individuals (both Members and Affiliated Professionals) who are not Members of the faculty of the University or are not employed by the City and County of San Francisco must maintain professional liability insurance in an amount not less than $2 million each occurrence, $6 million aggregate with an insurance carrier acceptable to the City's Risk Manager. Each such Member or Affiliated Professional must upon acceptance of the Medical Staff and thereafter at

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Dentists, podiatrists, and clinical psychologists;
UCSF physicians practicing medicine with the approval of the Medical Board of California under California Business and Professions Code 2113 or 2168 (foreign trained physicians).

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any time requested by the Credentials Committee, provide the Credentials Committee with written evidence of conforming coverage. Each such individual must promptly report to the Credentials Committee any reduction, restriction, cancellation for termination of the required insurance coverage or, if applicable, change of insurance carrier. Insurance requirements set forth in these Bylaws are subject to review by the City's Risk Manager, and may be updated by the City's Risk Manager from time to time as conditions warrant. The insurance requirements of this section may be modified on a case-by-case basis for good cause by the Hospital's Chief Executive Officer in consultation with the City's Risk Manager and the Chief of Staff.

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2.2.5. Participation in Medicare, Medicaid and Other Federal Health Care Programs

Applicants must:

A. Be eligible to participate in the Medicare, Medi-Cal, and other federal health care programs;

B. Obtain a National Provider Identifier (NPI); and

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C. Enroll in Medicare and/or Medi-Cal and receive an enrollment confirmation letter, excluding dentists and other providers whose professional services are not reimbursed by Medicare and/or Medi-Cal, respectively.

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2.3. Qualifications for Membership

In addition to meeting the basic qualifications, the Applicant must:

2.3.1. Experience, Education and Training

Document the Applicant's: (1) adequate experience, education, and training in the requested privileges; (2) current professional competence; (3) ability to perform the privileges requested; (4) good judgment; and (5) adequate physical and mental health to perform patient care activities, and demonstrate to the satisfaction of the Medical Staff that the Applicant is professionally and ethically competent to reliably provide the quality of care acceptable by the Medical Staff.

2.3.2. Ethics

Be determined: (1) to adhere to the lawful ethics of the Applicant's profession; (2) to work cooperatively with others in the Hospital setting so as not to adversely affect patient care or Hospital operations; and (3) to participate in and properly discharge Medical Staff responsibilities.

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2.4. Condition and Duration of Appointment

2.4.1. Governing Body Action

Initial appointment and reappointment to the Medical Staff is made by the Governing Body. The Governing Body will act on appointments, reappointments, or revocation of appointments only after a recommendation from the Medical Staff as provided in these Bylaws.

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Also note that we will review by rules and regs for the same 2- vs. 3-year term issue. Insert link to statute/reg/Joint Commission standard.

2.4.2. Duration

Initial appointments and reappointments to the Medical Staff will each be for a period of not more than two (2) years.

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2.4.3. Clinical Privileges

Appointments to the Medical Staff confer on the appointee only such Clinical Privileges as have been granted by the Governing Body, in accordance with these Bylaws.

2.4.4. Provide Care

Every Member will provide care and supervision of the Member's patients, abide by the Medical Staff Bylaws, accept committee assignments and, when appropriate, provide emergency service care and accept consultation assignments.

2.4.5. Non-Discrimination

Members must not discriminate in the provision of care to patients based on race, religion, color, national origin, ancestry, age, disability, medical status, sex, gender or sexual orientation, or any other basis prohibited by applicable local, state, or federal laws.

2.4.6. Division of Fees

The practice of division of fees under any guise whatsoever is prohibited and any such division of fees is cause for exclusion or expulsion from the Medical Staff.

2.5. Harassment Prohibited

Harassment by a Member against any individual (*e.g.*, against another Medical Staff Member, House Staff, Hospital personnel or patient) on the basis of race, religion, color, national origin, ancestry, age, disability, marital status, sex, gender or sexual orientation, or any other basis prohibited by applicable local, state, or federal laws will not be tolerated. All allegations of harassment will be investigated according to policies adopted by the City and/or University.

2.6. Nondiscrimination

No aspect of Medical Staff membership or Clinical Privileges and/or standardized procedures will be denied on the basis of race, religion, color, national origin, ancestry, age, disability, marital status, sex, gender or sexual orientation, or any other basis prohibited by local, state, or federal law. The credentialing and recredentialing processes will be conducted in a non-discriminatory manner and Members responsible for credentialing decisions will be required to sign an affirmative statement that they will make decisions in a non-discriminatory manner. Additionally, the Medical Staff must not discriminate with respect to staff privileges or the provision of professional services against a licensed physician and surgeon or podiatrist on the basis of whether the physician and surgeon or podiatrist holds an M.D., D.O., or D.P.M.

2.7. Effect of Other Affiliations

No person is entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely because the person holds a certain degree, is licensed to practice in this or any other state, is a Member of any professional organization, is certified by any Clinical Board, or because such person had, or presently has, staff Membership or privileges at another health care facility.

2.8. Basic Responsibilities of the Medical Staff

Each Medical Staff Member, Affiliated Professional and each Applicant exercising temporary privileges, must continuously meet all of the following responsibilities:

A. Provide the Member's or Affiliated Professional's patients with care that is of a generally recognized professional level of quality and efficiency;

B. Abide by the Medical Staff Bylaws and Rules and Regulations and all other lawful standards and policies of the Medical Staff and the Hospital;

C. Abide by applicable laws and regulations of government agencies, standards of the Joint Commission, and the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation;

D. Discharge such Medical Staff, Clinical Service, committee and service functions for which the Member, Affiliated Professional or Applicant exercising temporary privileges is responsible by appointment, election or otherwise; and

E. Complete new hospital orientation prior to exercising privileges.

F. Work cooperatively with Members, nurses, the Hospital Administration, and others so as not to adversely affect patient care or jeopardize the ability of the treatment team to provide quality patient care;

G. Report to their Service Chief any illness, disability, or absence which could affect patient care; and cooperate, at the Member's expense, with any health evaluations as may be reasonably required by the Medical Executive Committee;

H. Reporting to the Chief of Staff and their Service Chief within 7 days in the event of any formal action taken by government authorities to exclude the Member from participating in Medicare, Medicaid, or any other federal health care program;

I. Report to the Chief of Staff and their Service Chief within 7 days of: (1) any reduction, suspension, revocation, or termination of their Clinical Privileges and/or membership, for medical disciplinary cause or reason, at another licensed health care facility or medical group; (2) any certifying or licensing agency's initiation of an investigation, accusation, action, or settlement, (3) any surrender of license or certification, or (4) any felony charge or conviction of a misdemeanor or felony;

2.9. Non-Compliance With Basic Qualifications

An Applicant, Member or Affiliated Professional applying for reappointment who does not meet these basic qualifications is ineligible to apply for Medical Staff membership or reappointment and the application will not be accepted for review. If it is determined during the review process that an Applicant does not meet all of the basic qualifications, the review of the application will be discontinued. An Applicant who does not meet the basic qualifications is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific qualifications which adversely affected such Applicant, to the Credentials Committee.

Those comments and requests will be reviewed by the Credentials Committee and MEC, which has the sole discretion to determine whether the Applicant complies with the basic qualifications for Medical Staff membership.

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ARTICLE 3. CATEGORIES OF THE MEDICAL STAFF

The Medical Staff is divided into Active, Courtesy, Provisional, Administrative, and Inactive Staff categories.

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3.1. Active Medical Staff

The Active Medical Staff consists of physicians, dentists, clinical psychologists and podiatrists qualified for Medical Staff membership who spend the majority of their clinical effort treating patients under the direction of a Clinical Service of the Medical Staff at the Hospital or DPH healthcare facilities. Members of the Active Medical Staff must be appointed to a specific Clinical Service and are eligible to vote, to hold Medical Staff offices, and to serve on Medical Staff committees. Active Medical Staff Members are required to participate in Clinical Service conferences, meetings, and continuous quality improvement.

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3.2. Courtesy Medical Staff

The Courtesy Medical Staff consists of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who do not spend the majority of their clinical effort, or who spend an average of less than 4 hours per week, treating patients under the direction of a Clinical Service of the Medical Staff. Courtesy Medical Staff Members must be appointed to a specific Clinical Service and may serve on Medical Staff committees. Courtesy Medical Staff Members are not be eligible to hold Medical Staff Offices or to vote on amendments to these Bylaws and Rules and Regulations. Courtesy Medical Staff Members are encouraged, but not required, to participate in Clinical Service conferences and meetings; eligibility to vote at such conferences and meetings is at the discretion of the Chief of Service. Courtesy Medical Staff Members are required to participate in specific quality improvement activities that address their practice or involved them as a participant or witness.

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3.3. Provisional Medical Staff

The Provisional Medical Staff consists of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who have yet to complete initial proctoring requirements. Provisional Medical Staff Members must be appointed to a specific Clinical Service and may serve on Medical Staff Committees. Provisional Medical Staff Members are not be eligible to hold Medical Staff Offices or to vote on amendments to these Bylaws and Rules and Regulations. Provisional Medical Staff Members are required to participate in Clinical Service conferences and meetings; eligibility to vote at such conferences and meetings is at the discretion of the Chief of Service. Provisional Medical Staff Members are required to participate in specific quality improvement activities that address their practice or involved them as a participant or witness.

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3.4. Administrative Medical Staff

The Administrative Medical Staff consists of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who have a significant administrative medical role, have been granted access to Medical Records, and consult with other Members of

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the Medical Staff but who do not have Clinical Privileges or provide direct care to patients. Administrative Medical Staff Members need not be appointed to a specific Clinical Service and are eligible to vote, to hold Medical Staff offices, and to serve on Medical Staff committees. Administrative Medical Staff Members are required to participate in specific quality improvement activities that address their duties or involved them as a participant or witness.

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3.5. **Inactive Medical Staff**

The Inactive Medical Staff consists of physicians, dentists, clinical psychologists, and podiatrists qualified for Medical Staff membership who are missing one or more requirements to begin or continue practicing privileges. These requirements may include, but are not limited to, initial and annual hospital orientation and Environmental Health & Safety (EH&S) requirements such as TB testing and N95 fit testing. Inactive Medical Staff Members, when they have inactive status, are not eligible to vote, to hold Medical Staff offices, or to serve on Medical Staff committees. Inactive Medical Staff Members are required to participate in specific quality improvement activities that address their duties or involved them as a participant or witness.

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ARTICLE 4. APPOINTMENT AND REAPPOINTMENTS

4.1. General

4.1.1. Application Process

All applications for appointment and reappointment to the Medical Staff or as an Affiliated Professional of the Medical Staff must be in writing, signed by the Applicant, and submitted to the Medical Staff Services Department (MSSD) on a form approved by the Governing Body, upon recommendation of the Credentials Committee.

4.1.2. Application Content

Every Applicant for appointment or reappointment must furnish a fully completed application, and has the burden of producing accurate and adequate information for a proper evaluation of the Applicant's current clinical competence, character, and ethics. Information in applications must include:

A. Any previous denial, revocation, suspension, reduction, limitation, probation, loss or relinquishment, whether voluntary or involuntary, to a professional license or DEA license;

B. Voluntary or involuntary termination of Medical Staff membership or Affiliated Professional status, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or other health care organization;

C. A factual synopsis of all pending and resolved professional liability actions, asserted or active within the previous five (5) years;

D. For any resolved professional liability actions, a description of the judgment, arbitration award, settlement or other disposition; and

E. Attestation responses regarding the following issues:

   1) Reason for an inability to perform essential functions of the position;

   2) Violations of any criminal law or statutes;

   3) Denial, revocation, suspension, reduction, limitation, probation, loss or relinquishment of licensure; and

   4) Disciplinary activity or limitation of privileges and/or Medical Staff status.

4.1.3. Completion of Application

An application is "completed" when the Applicant has supplied all of the requested information and all necessary verifications have been obtained—including, but not limited to, current license, licensing board disciplinary records, specialty Board Certification status,

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National Practitioner Data Bank (NPDB) information, DEA certificate, if appropriate, training and practice from professional school through the present, current malpractice liability insurance and history, and reference letters, as specified in subsection 4.2.2 (Completed Application), below.

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4.1.4. Application Misrepresentation or Omission

Any significant misrepresentation or omission by an Applicant for appointment or reappointment is grounds for denial of the application or other appropriate corrective action, including revocation of Clinical Privileges and Medical Staff membership.

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4.1.5. Effect of Application

By applying for appointment or reappointment to the Medical Staff, each Applicant:

A. Signifies the Applicant's willingness to appear for interviews with the Medical Staff;

B. Authorizes the Medical Staff to consult with Medical Staff Members, administrators, or other personnel of other health care facilities with which the Applicant has been associated and who may have information bearing on the Applicant's competence, character, ethical qualifications, relevant mental and physical health, and any claims history;

C. Consents to the Medical Staff's inspection of all records and documents pertinent to the Applicant's current licensure, specific training, experience, current clinical competence and ability to perform the privileges requested and other matters that may be material to an evaluation of professional qualifications for Medical or Affiliated Staff membership;

D. Releases from any liability the Hospital, the Medical Staff, the Governing Body, the City, and the University, for any acts performed in good faith and without malice in connection with evaluating the Applicant's credentials; and

E. Certifies that the Applicant will promptly report to the MSSD any changes in the information submitted on the application which may subsequently occur.

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4.1.6. Applicant's Right to Be Informed

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Each Applicant has the right to be informed of the status of the Applicant's credentialing or recredentialing application upon request.

4.2. Initial Appointment Process

4.2.1. Applicant's Receipt of Medical Staff Information

The Applicant will be provided with a copy of, or access to, the Medical Staff Bylaws and Rules and Regulations, and Clinical Service Rules and Regulations governing the Applicant's specialty.

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4.2.2. Completed Application

The completed application for initial appointment must include: detailed information concerning the Applicant's professional qualifications, including, but not limited to, education, professional training, experience, licensure, relevant physical and mental health, disciplinary history, claims history, information regarding possible involvement in professional liability actions, biographical data, requests for Clinical Privileges, peer references, health care facility affiliations, current professional insurance coverage, documentation of additional appropriate

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licenses, certificates, or registrations required by law and/or the Medical Staff Bylaws and the appropriate Clinical Service Rules and Regulations, specialty board status, University faculty appointment status, and employment status; a signed agreement that the Applicant has read and will abide by the Medical Staff Bylaws and the appropriate Clinical Service Rules and Regulations; a release from liability for all parties engaging in good faith peer review, commencing with the credentialing process; and a signed statement of commitment to the confidentiality of all Medical Staff proceedings. It is the duty of the MSSD to provide an up to date copy of the Medical Staff Bylaws and the duty of the Clinical Service to provide an up to date copy of the Rules and Regulations to the Applicant for which the Applicant must attest.

4.2.3. Applicant's Burden and Incomplete Application

The Applicant has the burden of submitting complete, accurate, and adequate information for a proper evaluation of the Applicant's qualifications, including all requirements specified in the Medical Staff Bylaws, Medical Staff Rules and Regulations, and the Rules and Regulations of the department in relation to which that Applicant is seeking to work. This burden includes the burden of resolving any doubts about these matters and of providing any additional information requested by the Chief of Service, Chief of Staff, MSSD, or the Chair of the Credentials Committee. This burden also includes the Applicant paying any costs associated with verifications where the MSSD does not have access to the verification at issue. This burden may include submission to a medical, psychiatric, or psychological examination, at the Applicant's expense, if deemed appropriate by the MEC and, for City employees, as consistent with City rules. The Applicant's failure to sustain this burden or the provision of information containing any misrepresentations or omissions is grounds for denial of the application or subsequent termination, suspension, or limitation of Membership or Privileges under these Bylaws.

An incomplete application may not be processed. If an Applicant fails to complete the application within sixty (60) days after the date of initial submission, it may be considered voluntarily withdrawn on the sixtieth day after initial submission. If, prior to such voluntary withdrawal, the MSSD discovers that an application is incomplete, it will provide notice to the Applicant and the Chief of Service (or their designee) of the incomplete application as soon as possible (and no later than thirty (30) days before the deadline). Such voluntary withdrawal does not entitle the Applicant to the rights set forth in these Bylaws. The Credentials Committee may, for a good cause, extend the time for completion of the application.

4.2.4. Recommendation for Medical or Affiliated Staff Membership, and Clinical Privileges

When the MSSD has received all necessary verifications, the completed application, all supporting documentation, and other relevant information (collectively the "File"), it will submit the File to the Chief of Service for review and recommendations regarding membership and Privileges. The Chief of Service will then forward their written recommendations to the Credentials Committee. If the Applicant is seeking privileges in more than one Clinical Service, then the File will be submitted to all applicable Chiefs of Service for written recommendations once all verifications are received.

4.2.5. Credentials Committee Review and Action

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The Credentials Committee will review the completed application and File and the Chief of Service's recommendations at the next regularly scheduled Credentials Committee meeting. The Credentials Committee, or a subcommittee thereof, may interview the Applicant if there are contents of the application or File that require clarification in person. The Credentials Committee will then submit to the MEC its written report and recommendations as to membership and Privileges.

4.2.6. Medical Executive Committee Review and Action

At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Committee, the MEC will review the Credentials Committee's report and recommendations and make a recommendation to the Governing Body, through the Director of Health, that the application be approved, denied, or deferred for further consideration. All recommendations to approve an application must also specifically recommend the Clinical Privileges to be granted and any special conditions or limitations relating to such Privileges. When the recommendations are adverse to the Applicant, the MEC will document the reasons for such recommendations in its minutes.

A. When the recommendation of the MEC is favorable to the Applicant, it will be forwarded to the Governing Body, through the Director of Health.

B. When the recommendation of the MEC is to defer the application for further consideration, the MEC must reconsider the application at its next regularly scheduled meeting.

C. When the recommendation of the MEC is adverse to the Applicant in respect to appointment or specific Privileges, the Chief of Staff will promptly notify the Division/Chief of Service. The Chief of Staff will also notify the Applicant by Notice in accordance with Section 7.3 of these Bylaws. The Governing Body will be generally informed of the recommendation for informational purposes, but it will not act on it.

D. An Applicant who has received an adverse recommendation from the MEC as part of their initial appointment for privileges is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific qualifications which adversely affected such Applicant, to the Credentials Committee and MEC.

E. Those comments and requests will be reviewed by the Credentials Committee and MEC, which has the sole discretion to determine whether the Applicant should receive a favorable recommendation for Medical or Affiliated Staff membership.

4.2.7. Governing Body Review and Action

The Governing Body will act upon a favorable recommendation at its next regularly scheduled meeting and notify the Applicant of its decision. If the Governing Body's decision is adverse to the Applicant in respect to reappointment or Clinical Privileges, the Chief of Staff, upon receiving notice of the Governing Body's decision, will promptly notify the Applicant and Chief of Service of such adverse decision by Notice in accordance with Section 7.3 of these Bylaws. Such adverse decision will be held in abeyance until the Applicant has exercised, or has been deemed to have waived, the Applicant's procedural rights under Articles 6 and 7 of these

Bylaws. The fact that the adverse recommendation or decision is held in abeyance during the hearing and appellate review does not confer Privileges where none existed before, and any Privileges that have expired are not extended by such hearing or review.

A. In the event the Governing Body wishes to defer action, it may do so by referring the matter back to the MEC with a statement of its reasons for doing so. Any such referral to the MEC must set a time limit (not to exceed sixty (60) days) for the MEC to provide additional information or recommendations or take further action.

B. The final decision of the Governing Body must be made within forty-five (45) days of its receipt of the recommendation of the MEC. This final decision will be promptly forwarded to the MEC and the Applicant.

C. The time periods set forth in this section are guidelines only, not directives that create any right for an Applicant to have an application processed within these precise periods. When no time periods are specified, all parties will act as soon as reasonably practicable.

4.3. Reappointment Process

4.3.1. Frequency

The Medical Staff must reevaluate Members at least every two (2) years for the purpose of determining its recommendations for reappointment to the Medical or Affiliated Staff and the continuation of Clinical Privileges.

4.3.2. Reappointment Application Process

At least one hundred twenty (120) days before the expiration of a Member's appointment, the MSSD must email the Member a reappointment application. Within thirty (30) days of the date the application was emailed, the Member must return the completed application to the MSSD, along with all required information and materials.

4.3.3. Recommendation for Reappointment

Within thirty (30) days of the completed application for reappointment, the MSSD must email the completed application to the Chief(s) of the Service(s) in relation to which the Applicant is requesting Privileges. Each Chief of Service for a Service in relation to which the Member requests or has exercised Privileges must review the Member's completed File and forward the Chief of Service's written recommendations to the Credentials Committee. The recommendations will include a statement that the recommendations are based on the Clinical Service's performance improvement information for the Medical Staff Member or Affiliated Professional, any professional liability claims, the Member's clinical activity, education, and training, and any other pertinent information. The Chief of Service(s) must return the application with written recommendation no less than sixty (60) days before the expiration of the Member's appointment.

In addition to the items listed in this subsection 4.3.3, each recommendation concerning reappointment of a Member and the Clinical Privileges to be granted upon reappointment must be based upon such Member's current professional performance including, but not limited to, ongoing Professional Practice Evaluation (OPPE) data, performance reviews, evidence of progression towards Board Certification or re-certification (if applicable), current competence, clinical or technical skills and judgment in the treatment of patients, ongoing provider specific continuous quality improvement evaluations, ethical conduct, attendance at Medical Staff

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meetings and participation in Medical Staff affairs, compliance with these Bylaws and Rules and Regulations, voluntary or involuntary loss and/or relinquishment of Privileges or licensure, results from the National Practitioner Data Bank inquiry, and mental or physical health that permits the Member to carry out the essential functions of the Member's Medical Staff category, Privileges, or Standardized Procedures with or without reasonable accommodation.

4.3.4. Credentials Committee Review and Action

The Credentials Committee will review the completed application and File and the Chief of Service's recommendations at the next regularly scheduled Credentials Committee meeting. The Credentials Committee, or a subcommittee thereof, may interview the Applicant if there are contents of the application or File that require clarification in person. The Credentials Committee will then submit to the MEC its written report and recommendations as to membership and Privileges.

4.3.5. Medical Executive Committee Review and Action

At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Committee, the MEC will review the Credentials Committee's report and recommendations and make a recommendation to the Governing Body that the application be approved, denied, or deferred for further consideration. All recommendations to approve an application must also specifically recommend the Clinical Privileges to be granted and any special conditions or limitations relating to such Privileges. When the recommendations are adverse to the Applicant, the MEC will document the reasons for such recommendations in its minutes.

D. When the recommendation of the MEC is favorable to the Applicant, it will be forwarded to the Governing Body.

E. When the recommendation of the MEC is to defer the application for further consideration, the MEC must reconsider the application at its next regularly scheduled meeting.

F. When the recommendation of the MEC is adverse to the Applicant in respect to reappointment or Clinical Privileges, the Chief of Staff will promptly notify the Division/Chief of Service. The Chief of Staff will also notify the Applicant by Notice in accordance with Section 7.3 of these Bylaws. The Governing Body will be generally informed of the recommendation for informational purposes, but it will not act on it until after the Applicant has exercised, or has been deemed to have waived, the Applicant's procedural rights set forth in Articles 6 and 7 of these Bylaws.

4.3.6. Governing Body Review and Action

The Governing Body will act upon favorable recommendation at its next regularly scheduled meeting and notify the Applicant of its decision. If the Governing Body's decision is adverse to the Applicant in respect to reappointment or Clinical Privileges, the Chief of Staff, upon receiving notice of the Governing Body's decision, through the Director of Health, will promptly notify the Applicant and Chief of Service of such adverse decision by Notice in accordance with Section 7.3 of these Bylaws. Such adverse decision will be held in abeyance until the Applicant has exercised, or has been deemed to have waived, the Applicant's procedural

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Credentials Committee Action¶
The Credentials Committee shall will review the completed reappointment application and fFile and the Clinical Service ChiefChief of Service's final recommendations at the next regularly scheduled Credentials Committee Meeting. The Credentials Committee, or a subcommittee thereof, may interview the Applicant if there are contents of the applicationFile that require clarification in person. The Credentials Committee shall will then submit to the MEC its written report and recommendations as to reappointment and Privileges.¶
Medical Executive Committee Action¶
At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Committee, the MEC shall will review the Credentials Committee's report and recommendations, and will make recommendations to the Governing Body that the application be approved, denied, or deferred for further consideration.¶
When the recommendations include a denial of reappointment or a reduction in Clinical Privileges, the MEC shall must document the reasons for such recommendations in the minutes. Thereafter, the procedures set forth in Sectionsubsection 4.2.6 above shall will apply.

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rights under Articles 6 and 7 of these Bylaws. The fact that the adverse recommendation or decision is held in abeyance during the hearing and appellate review does not confer Privileges where none existed before, and any Privileges that have expired are not extended by such hearing or review.

G. In the event the Governing Body wishes to defer action, it may do so by referring the matter back to the MEC with a statement of its reasons for doing so. Any such referral to the MEC must set a time limit (not to exceed sixty (60) days) for the MEC to provide additional information or recommendations or take further action.

H. The final decision of the Governing Body must be made within forty-five (45) days after additional information is provided by MEC. This final decision will be promptly forwarded to the MEC and the Applicant.

I. The time periods set forth in this section are guidelines only, and are not directives that create any right for an Applicant to have an application processed within these precise periods. When no time periods are specified, all parties will act as soon as reasonably practicable.

4.3.7. Term of Reappointment

Reappointments to any Medical Staff category will be for a maximum of two (2) years.

4.3.8. Failure to Return a Completed Reappointment Application

If the Member has not returned a completed reappointment application to the MSSD within thirty (30) days of the email required under subsection 4.3.2, above, then the MSSD will email a final reminder allowing a fifteen (15) day extension from the date of the reminder email. Failure of a Medical Staff Member or Affiliated Professional to return a completed application for reappointment at least seventy-five (75) days prior to the expiration of the Member's current term may result in automatic resignation of the Member's Privileges effective on the date the Member's current term expires. The respective Chief of Service will be notified in writing of the delinquent reappointment and pending termination. After the passing of the 15-day extension period and after the Chief of Service is notified, the MSSD will check with the Chief of Service regarding the status of the Member's Privileges, including regarding any discussion of submission of the reappointment application. If no progress has been made by the Member in addressing the reappointment application submission, the MSSD will forward information about the potential automatic resignation of the Member's Privileges to the Credentials Committee for review and a final decision regarding the automatic resignation. A Member who automatically resigns under this section will be processed as a reappointment if the Member submits a completed reappointment application within thirty (30) days from the date of termination.

4.3.9. Reapplication After Adverse Decision

An Applicant or Member who has received a final adverse decision regarding appointment, reappointment, membership, Privileges, or who has resigned after notice of an adverse recommendation or a final adverse decision, is not eligible to reapply to the Medical or Staff or for appointment as an Affiliated Professional for a period of two (2) years from the date of the final adverse decision or resignation. Thereafter, the Applicant may apply as a new

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Applicant and must submit information to demonstrate that the basis for the earlier adverse decision or recommendation no longer exists.

4.4. **Access to Own Credentials File**

Each Member will be provided with access to information in the Member's own credentials file subject to the following provisions:

A. The Member may receive a copy of only those documents provided by or addressed to the Member as well as all Ongoing Professional Practice Evaluation and/or Focused Professional Practice Evaluation reports (OPPE and FPPE reports, respectively); and

B. A summary of peer review information, committee findings, letters of reference, proctoring reports, and complaints will be provided to the Member by the Chief of Staff within thirty (30) days of receipt of such a request. Summaries of peer review materials will disclose the substance, but not the source, of the information.

4.5. **Right to Request Corrections/Additions**

Members may exercise the right to request corrections or additions to their credentials file following the protocol set forth below:

A. Members have the right to add to the Member's own credentials file a statement responding to any information contained in the file;

B. A Member may submit a written request to the Chief of Staff for the correction or deletion of information in the credentials file. Such requests must include a statement of the basis for the action requested;

C. The Chief of Staff will recommend to the MEC whether or not to make the requested correction or deletion;

D. The MEC will approve or deny the Chief of Staff's recommendation by a majority vote; and

E. The Member will be notified by the Chief of Staff of the decision of the MEC. The decision of the MEC is final.

4.6. **House Staff**

House Staff are not eligible for Medical Staff membership.

4.7. **Affiliated Professionals**

4.7.1. General

A. Affiliated Professionals are individuals who:

1) Are employees of the City, or faculty or employees of the University, or functioning under an MOU approved by the MEC and Governing Body, and provide health services requiring them to exercise independent judgment within the area of the Affiliated Professional's professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable State laws;

2) Do not qualify for Medical Staff membership because they are not licensed as physicians, dentists, clinical psychologists, or podiatrists; and

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3) Belong to one of the following professional categories:

- Licensed Acupuncturists
- Certified Nurse Midwives
- Certified Registered Nurse Anesthetists
- Nurse Practitioners
- Physician Assistants
- Clinical Pharmacists (PharmD)
- Optometrists
- Genetic Counselors.

B. Although not eligible for Medical Staff membership, Affiliated Professionals are credentialed through the Medical Staff and are subject to general Medical Staff oversight.

C. The clinical responsibilities of each Affiliated Professional must be set forth in privileges developed by the Committee on Interdisciplinary Practice and approved by the Credentials Committee, MEC, and the Governing Body. Note that any reference in these Bylaws to privileges for Affiliated Professionals includes both concepts as appropriate for the situation.

4.7.2. Role of Medical Staff

A. Affiliated Professionals practice within the scope of the Affiliated Professional's licensure and as otherwise consistent with applicable Hospital and Medical Staff policies, procedures, or privileges. To the extent that state regulations require supervision of Affiliated Professionals beyond overall Medical Staff oversight, the additional supervisory relationship will occur as required by law.

B. As employees of either the City or the University, Affiliated Professionals are recruited and hired through the usual personnel processes of each respective employing entity. Any clinical activity is contingent upon Medical Staff approval following the procedures set forth below.

4.7.3. Appointment

A. Each Affiliated Professional who has been provisionally hired must submit an application to the MSSD for appointment to Affiliated Professional status. The Applicant must furnish all information required on the application form or reasonably requested by the Interdisciplinary Practice Committee, Credentials Committee, or the MEC. The Applicant has the burden of producing adequate information for a proper evaluation of competency, character, and ethics. An Applicant who fails to provide all requested information within thirty (30) days of the date of being notified of any deficiencies will be deemed to have withdrawn the application.

B. An Applicant who is on the Office of Inspector General (OIG) Exclusion List is not eligible for appointment as an Affiliated Professional.

C. An Applicant must possess a National Provider Identifier (NPI) or must have submitted an application for an NPI in order to be considered for appointment or reappointment as an Affiliated Professional.

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D. An Applicant must possess a DEA certificate or have submitted the application for a DEA certificate unless the Applicant will be working in an area where no medications are prescribed (such as Radiology or Pathology) or whose licensure does not allow prescribing medications.

E. An Applicant must have enrolled in Medicare and received an enrollment confirmation letter, excluding PharmDs whose professional services are not reimbursed by Medicare and Nurse Practitioners hired prior to April 2004 without a master's degree.

F. Nurse Practitioners hired by the City or University after April 2004 must have a master's degree in nursing and be board-eligible.

G. The MSSD will forward the completed application to the Chair of the Interdisciplinary Practice Subcommittee of the Credentials Committee. The Interdisciplinary Practice Subcommittee will review the application and will forward the application together with its recommendation to the Credentials Committee.

H. The Credentials Committee will review the application and make a recommendation to the MEC.

I. The MEC will review the recommendation of the Credentials Committee and make a recommendation to the Governing Body.

J. The Governing Body will review the recommendation of the MEC and will make a decision whether to approve the Affiliated Professional.

K. If the Governing Body denies the Applicant's admission to Affiliated Professional status, the Applicant is limited to the remedies set forth in the Grievance Procedures in the applicable Memorandum of Understanding. The Applicant is not entitled to any of the procedural rights set forth in these Bylaws.

L. Services that require a privilege or standardized procedure may not be performed until the Applicant's credentials and privileges or appointment have been approved by the Medical Staff.

M. An Affiliated Professional who is admitted to Affiliated Professional status is subject to a period of proctoring/evaluation under rules and procedures established by the relevant clinical service.

N. By applying for Affiliated Professional status, the Applicant must comply with and agrees to the same provisions that apply to Applicants for Medical Staff membership set forth in the following Sections and subsections of these Bylaws;

   a. Subsection 2.2.4 (Professional Liability Insurance);

   b. Subsection 2.2.5 (Participation in Medicare, Medicaid and other Federal Health Care Programs);

   c. Section 2.3 (Qualifications for Membership);

   d. Section 2.5 (Harassment Prohibited);

   e. Section 2.8 (Basic Responsibilities of the Medical Staff);

O. Subsection 4.1.3 (Completion of Application);

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a. Subsection 4.1.4 (Application Misrepresentation or Omission); and

P. Subsection 4.1.5 (Effect of Application).

Q. Any material misrepresentation by an Applicant is grounds for denial of the application or for termination of Affiliated Professional status.

4.7.4. Reappointment

A. The initial appointment to Affiliated Professional status will last for a maximum period of two (2) years.

B. Each subsequent reappointment will be for a maximum two (2) year period.

C. Prior to the end of each appointment or reappointment period, the MSSD will provide the Affiliated Professional with an application for reappointment, and the application for reappointment must be submitted and processed according to the same procedures as for the initial appointment and is subject to the same restrictions.

4.7.5. Corrective Action

A. Any corrective employment action against an Affiliated Professional must be done in accordance with the procedures set forth in the applicable City or University employment Memorandum of Understanding (MOU) or other applicable employment policies and rules. The Affiliated Professional is not be entitled to any of the procedural rights set forth in these Bylaws.

B. In the event that immediate action is necessary to prevent imminent danger to the health or safety of any individual, the Affiliated Professional's right to perform some or all duties set forth in their Job Description may be suspended immediately, in accordance with the procedures set forth in the applicable MOU. In addition, any clinical privileges or standardized procedures exercised by an Affiliated Professional that is overseen by the Medical Staff may be addressed by the Medical Staff using concepts similar to those listed in Article 6 (Corrective Action) of these Bylaws at the discretion of the Chief of Staff or MEC without affording the Affiliated Professional any procedural rights listed in Article 6. Similarly, the Chief of Service may, in consultation with the Chief of Staff, address allegations of inappropriate behavior by Affiliated Professionals using the concepts listed in this subsection 6.2.2, although there are no specific requirements of using any specific concept or process listed in this section. An Affiliated Professional is not be entitled to any of the procedural rights set forth in these Bylaws.

ARTICLE 5. CLINICAL PRIVILEGES

5.1. Clinical Privileges

5.1.1. Process

Members and Affiliated Professionals are entitled to exercise only those Clinical Privileges specifically granted to them by the Governing Body except as provided in Section 5.2 herein regarding temporary privileges, or to practice within . The granting of Privileges depends upon an individual's documented experience in categories of diagnostic and treatment areas and current competence as judged by ongoing continuous quality improvement reviews. The Rules and Regulations of each Clinical Service specify the Clinical Privileges for that Service.

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Clinical Privileges or appointment with Standardized procedures are required for the provision of telehealth services. Specific privileges may cover the provision of both in-person and telehealth services. Privileges or standardized procedures for Members or Affiliated Professionals who provide only telehealth services are subject to the same requirements that apply to all privileges.

5.1.2. Education, Training and Experience

Every initial application for Medical Staff or Affiliated Professional appointment must contain a request for specific Clinical Privileges desired by the Applicant. The evaluation of such requests must be based upon the Applicant's documented education, training, experience and demonstrated competence, University faculty appointment (if applicable), references, and other relevant information, including a recommendation by the Chief of Service in which such Privileges are sought. The Applicant has the burden of demonstrating qualifications and competency in the requested Clinical Privileges or Appointment as an Affiliated Professional.

5.1.3. Evaluation

Ongoing monitoring of Clinical Privileges is based on a variety of modalities which can include but not be limited to direct observation of the care provided, review of medical records, and other peer review activities.

5.2. Temporary Appointments with Clinical Privileges

5.2.1. Pending Application for Permanent Medical or Affiliated Staff Membership

A. In the event that there is a compelling patient care need which the Chief of Service could not have anticipated, the Chief of Staff in consultation with both the CEO (or designee) and the Chair of the Credentials Committee, may grant temporary appointment with Privileges to an Applicant who has a Clean Application ~~Credentials~~ is pending the next meeting of the Governing Body for final approval.

B. No person with Temporary Privileges or Affiliate status may vote or hold office.

C. Temporary Privileges or Temporary Affiliate status may be granted for a period not to exceed sixty (60) days.

5.2.2. Application and Review

The Chief of Staff, with the concurrence of the Chief Executive Officer, may grant Temporary Privileges or Temporary Affiliate status after the following has been completed:

A. The Chair of the Credentials Committee has determined that the Applicant has a "Clean Application" as defined in the Definition section of these Bylaws.

B. The Chief of Service provides the Chief of Staff with a compelling patient care need that could not have been anticipated and that requires that the services of the Applicant begin before the application can be approved at the next meeting of the Governing Body.

5.2.3. General Conditions

A. There is no right to Temporary Privileges or Temporary Affiliate Status. They may be granted at the sole discretion of the Chief of Staff only after a Clean Application has been approved by the Chair of the Credentials Committee.

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B. A determination to grant Temporary Privileges or Temporary Affiliate Status is not binding or conclusive with respect to an Applicant's pending request for appointment to the Medical or Affiliated Staff.

C. In exercising Temporary Privileges or Standardized Procedures, the Applicant will act under the supervision of the Chief of Service, or designee, to whom the Applicant is assigned and will be proctored and monitored in accordance with the Clinical Service Rules and Regulations and the proctoring provisions set forth in these Bylaws.

D. Temporary Privileges or Temporary Affiliate Status will not be granted unless the Applicant has an academic appointment with the University, is an employee of the City, or provides documentation of professional liability insurance coverage in accordance with subsection 2.2.4 of these Bylaws.

E. Temporary Privileges or Temporary Affiliate Status will not be granted unless the Applicant signs an acknowledgment that the Applicant has received, or been given access to, a copy of the Medical Staff Bylaws and agrees to be bound by the Bylaws.

F. The Chief of Staff may use the Chief's discretion to restrict, suspend, or terminate any or all of the Temporary Privileges or Standardized Procedures granted. In such an event, the Member Applicant is not entitled to the procedural rights set forth in Article 6 of these Bylaws, or to any other procedural rights, unless such action requires the filing of a report to either the Member Applicant's professional licensing organization (such as the Medical Board of California) or the National Practitioner Data Bank.

5.3. Visiting Privileges

5.3.1. To Meet a Specific Need

G. Visiting Privileges may be granted for a specified period of time, not exceeding ninety (90) days, on a case-by-case basis when a patient (or patients) of a Clinical Service requires the services of a physician, dentist, podiatrist, clinical psychologist or Affiliated Professional who is not a Member of the Medical or Affiliated Staff. If the individual with Visiting Privileges desires to join the Medical Staff, the individual must submit an application as a new appointment. No person with Visiting Privileges may vote or hold office. (Note: ZSFG Administrative Policy 22.06 refers to this position as "Consulting Clinical Physician".) The Chief of Staff, with the concurrence of the Chief Executive Officer, may authorize Visiting Privileges if:

1) The person has submitted a completed application for Visiting Privileges or Affiliated Professional Status;

2) The Chief of Staff reasonably believes that the person has the qualifications, ability, and judgment required for Medical or Affiliated Staff membership;

3) The Chief of Service requiring a person's services recommends the person; and

4) The Chief of Service has provided, in writing, the clinical need for granting such Privileges.

5.3.2. General Conditions

A. In exercising Visiting Privileges, the Applicant must act under the supervision of the Chief of Service, to which the Applicant is assigned.

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B. Visiting Privileges or Affiliate Status must not be granted unless the Applicant has an academic appointment with the University, is an employee of the City, or provides documentation of professional liability insurance coverage in accordance with subsection 2.2.4 of these Bylaws.

C. Visiting Privileges or Affiliate Status will not be granted unless the Applicant signs an acknowledgment that the Applicant has received, or been given access to, a copy of the Medical Staff Bylaws and agrees to be bound by them.

D. The Chief of Staff may use the Chief's discretion to restrict, suspend, or terminate the Visiting Privileges or Affiliate Status. In such an event, the provider is not be entitled to the procedural rights set forth in Articles 6 and 7 of these Bylaws, or to any other procedural rights, unless such action requires the filing of a report to either the Member Applicant's professional licensing organization (such as the Medical Board of California) or the National Practitioner Data Bank.

E. The Chief of Staff will present the candidate to the Governing Body for approval with a rationale regarding why Visiting Privileges or Affiliate Status should be granted.

F. All requirements of ZSFG Administrative Policy 22.06 (including as it is amended in the future) must be met.

5.4. Emergency Situations and Privileges or Affiliate Status

5.4.1. Emergency Situations When More Qualified Healthcare Personnel Are Not Available

In the event of an emergency, any qualified Member or Affiliated Professional is allowed to do everything reasonable to save the life of a patient or to save a patient from serious harm. The Member or Affiliated Professional must promptly yield such care to more qualified healthcare personnel when available.

5.4.2. Emergency Situations Pertaining to a Single Patient or a Few Patients

In the event of an emergency or critical situation where no Member or Affiliated Professional possesses the expertise necessary to save the life of a patient or to save a patient from serious harm, the Chief of Staff may grant emergency Privileges or Affiliate Status to a licensed Practitioner, who has an academic appointment with the University and who possesses the requisite qualifications and expertise to treat the patient or a few patients, at the discretion of the Chief of Staff. In the event that no qualified Practitioner with an academic appointment at the University is available within the necessary clinical time frame, the Chief of Staff may grant emergency Privileges or Affiliate Status to a Practitioner with a license recognized by the state of California who possesses the requisite qualifications and expertise to treat the patient(s). Care provided under emergency Privileges or Affiliate Status will be documented in the hospital medical record related to each patient treated by that provider, and a record of the Practitioner's emergency Privileges or Affiliate Status will be maintained by the MSSD, including the Practitioner's name and license, the name and medical record number of any patients treated by that Practitioner, and the dates of service. MSSD will perform primary source verification of the medical license and verification of malpractice coverage as soon as possible.

5.4.3. General Emergency Situations

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General emergency situations may arise due to a disaster, such as an earthquake, weather emergency, or fire, due to an infectious disease, due to an extreme staffing shortage, or due to other circumstances. Any time such a general emergency situation arises, including but not limited to any time the Hospital activates its Emergency Management Plan, Members and Affiliated Professionals who are qualified based on training or experience may perform expanded roles outside the scope of their normal Privileges or Standardized Procedures at the discretion of the Chief of Staff in consultation with leadership from the affected clinical service areas without requiring that new Privileges be granted. The clinical services being supported by such qualified Members and Affiliated Professionals will provide any additional orientation or training that is necessary and ongoing supervision and oversight of the provider during the emergency. Services provided in relation to such general emergency situations are subject to the following requirements based on the duration of the emergency:

A. Emergency Privileges or Affiliated Status for Service Less than One Month

1) In the event Practitioners present themselves to the Hospital during an emergency, including but not limited to when the Hospital activates its Emergency Management Plan, and the Hospital is unable to handle the immediate patient needs, Emergency Privileges or Affiliated Status may be granted by the Chief Executive Officer, the Chief of Staff, the Chief Executive Officer's designee(s), or the Chief of Staff's designee(s) to providers for services less than one month in duration upon presentation of the following information, with a record to be kept by the MSSD when feasible:

a. A valid government-issued photo identification card such as a driver's license or a passport, and

b. At least one of the following:

i. A copy of a current license to practice;

ii. Primary source verification of licensure;

iii. Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;

iv. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in emergency circumstances; or

v. Confirmation by a Member or an Affiliated Professional with personal knowledge of the volunteer provider's ability to act as a licensed independent provider during an emergency.

2) During the emergency, the Medical Staff will oversee the performance of each Practitioner who has been granted emergency privileges or Affiliated Status. Based on its oversight of such Practitioner, the Medical Staff will determine within seventy-two (72) hours, and on an ongoing basis as needed after that, of the Practitioner's arrival if the emergency privilege should continue. Practitioners granted emergency Privileges or Affiliated Status must document the care they provide in a manner similar to Members of the Medical Staff when feasible.

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3) Primary source verification of licensure and confirmation of malpractice coverage must occur as soon as the emergency is under control or within seventy-two (72) hours from the time the provider presented to the Hospital, whichever comes first. If verification cannot be completed within seventy-two (72) hours due to extraordinary circumstances, the following must be documented and maintained by the MSSD:

   a. The reason(s) verification could not be performed within seventy-two (72) hours;

   b. Evidence of the provider's demonstrated ability to continue to provide adequate care, treatment, and services; and

   c. Evidence of the Hospital's attempt to perform primary source verification as soon as possible.

   Primary source verification of licensure is not required if the provider has not provided care, treatment, or services under the emergency Privileges or Standardized Procedures.

4) When additional assistance is required by a clinical service due to an extreme staffing shortage and an outside provider is identified who can capably perform the required duties, the Chief of Staff may grant emergency Privileges or Affiliate Status to be overseen by the clinical service and Chief of Service or the Chief of Service's designee. The MSSD will keep a record confirming the Chief of Service's or designee's agreement to the appointment and attestation that the provider can adequately perform the necessary clinical care. The MSSD will determine the source of the provider's malpractice coverage, the provider will be granted access to the Hospital's medical record system, and the provider will be given Hospital identification.

B. Emergency Privileges or Affiliate Status for Service More than One Month

The Medical Staff or Affiliated Professionals will use Emergency Privileges or Standardized Procedures using the procedures described above for emergency service less than one month. Once Hospital Leadership or the Chief of Staff determine that emergency service will be needed for more than one month, the Medical Staff will, within one month of emergency Privileges or Affiliate Status being granted to the provider, request that the provider apply for regular Hospital Privileges or Affiliate Status. If the provider declines to apply for regular Privileges or Affiliate Status, the Chief of Staff or designee may extend Emergency Privileges or Affiliate Status for a maximum of three additional months, for a total of no longer than four months of emergency privileges for that provider in most situations. The Chief of Staff may extend emergency privileges to cover the time period while the application for regular Hospital privileges is in process, which should not generally exceed three months from the time the provider submits the application. For Emergency Privileges or Affiliate Status longer than one month, the Chief of Staff will update the Governing Body of such Emergency Privilege or Affiliate Status s.

5.5. **Visiting Physicians and other Categories of Practitioners**

ZSFG Administrative Policy 22.06 "Visiting Physicians" (see Appendix 2) defines "Consulting Clinical Physician", "Consulting Academic Physician", "Physician Observer", and "Visiting Research Physician". Physicians in these roles and Practitioners who would fall within

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Emergency Management Plan Activated
In the event that the Emergency Management Plan has been activated and the Hospital is unable to handle the immediate patient needs, Disaster Privileges may be granted by the Chief Executive Officer, the Chief of Staff, the Chief Executive Officer's designee(s), or the Chief of Staff's designee(s) upon presentation of the following:
A valid government issued photo identification card such as a driver's license or a passport, and at least one of the following:
A copy of a current license to practice medicine;
Primary source verification of licensure;
Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps. (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;
Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or
Confirmation by a licensed independent practitioner currently privileged by the Hospital, or by a Member, with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.
Physician Oversight
During the disaster, the Medical Staff shall oversee the performance of each physician who has been granted disaster privileges. Based on its oversight of such physicians, the Medical Staff shall determine within seventy-two (72) hours of the physician's arrival if the disaster privilege should continue.
Primary Source Verification
Primary source verification of licensure shall occur as soon as the disaster is under control or within seven ... [2]

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the category of Affiliated Staff do not have Privileges or Standardized Procedures unless specifically granted under Section 5.3, above, may not direct patient care, do not have access to medical records, and must follow all requirements of ZSFG Administrative Policy 22.06.

for their specific category regarding:

A. Their role in interacting with the patient and Members.

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B. Maintenance of professional liability coverage must be either through their primary institution or own insurance company.

C. Sponsorship by the Chief of the sponsoring Clinical Service, or for Visiting Research Physicians, the Principal Investigator with the consent of the Chief of Service.

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D. Immunizations—if in patient care settings, must meet same requirements as clinical staff.

E. Orientation as applicable for the specific category.

F. Identification badges if in patient care areas.

G. Required patient consent if interacting with or observing patients.

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5.6. **Proctoring**

5.6.1. General

All new appointees to the Medical and Affiliated Staff and existing Members requesting additional Privileges or Standardized Procedures, regardless of specialty or category of membership, will be assigned a Proctor by the Chief of Service and complete a period of proctoring, as defined in subsection 5.6.4, below.

The Proctor must have unrestricted Privileges or Standardized Procedures to perform the evaluation(s) that the Proctor will conduct. The Chief of Service will submit a form to the Credentials Committee attesting to the satisfactory completion of proctoring. Documentation of the proctoring will reside in the Clinical Service Office.

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5.6.2. Function and Responsibility of the Proctor

H. The Proctor is responsible for evaluating the provider's clinical competence for the requested privileges or standardized procedures.

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I. The Proctor's primary responsibility is to evaluate the Proctoree's performance. However, if the Proctor believes intervention is warranted in order to avert harm to a patient, the Proctor may take any action the Proctor finds reasonably necessary to protect the patient.

5.6.3. Responsibility of the Proctoree

The Proctoree is responsible for notifying one of the assigned Proctors for each patient whose care is to be evaluated. For surgical or invasive medical procedures that will be observed, the Proctoree is responsible for arranging the time of the procedure with the Proctor.

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5.6.4. Proctoring Duration

Proctoring will be deemed successfully completed when the Proctoree completes the proctoring as described in the Clinical Service Rules and Regulations. Proctors may begin proctoring upon initial granting of Privileges or Affiliate Status with the goal of completing

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proctoring within the first six months after the initial grant, but in any case must complete proctoring within the first twelve (12) months of initial granting of new Privileges or Affiliate Status.

For Privileges or Standardized Procedures that are infrequently performed by the Member, the Chief of Service may submit a written request to the Credentials Committee to expand the proctoring period. Alternatively, the Chief of Service may request that proctoring occur at another accredited hospital. These Privileges or Standardized Procedures must be voluntarily relinquished or withdrawn if proctoring is not completed within twenty-four (24) months of the initial granting of the infrequently performed Privileges or Standardized Procedures unless the MEC and the Governing Body approve an extension.

5.6.5. Reciprocal Proctoring

Reciprocal proctoring is proctoring that is performed by non-Hospital Members at sites other than the Hospital. Reciprocal proctoring may be accepted when no Hospital Members who possess the necessary expertise are available to proctor a specific skill or procedure. Only such specific skills or procedures may be reciprocally proctored; all other elements of the Applicant's practice must be proctored by a Medical or Affiliated Staff Member of the Hospital. Requirements for reciprocal proctoring are as follows:

J. The reciprocal Proctor is an active member of the medical or affiliated staff at another accredited hospital;

K. The reciprocal Procter possesses unrestricted Privileges to perform the procedure for which the proctoring is being performed; and

L. The Chief of Service has approved the reciprocal proctoring arrangement and the reciprocal Procter.

For each case that is reciprocally proctored, the reciprocal Proctor must complete a Hospital proctoring form and submit it to the Clinical Service. The Clinical Service will submit an evaluation summary to the Credentials Committee.

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MEDICAL STAFF BYLAWS

ARTICLE 6. MONITORING AND CORRECTIVE ACTION

6.1. Routine and Issue-Related Monitoring

6.1.1. Routine Monitoring and Education, Including Verbal and Written Counseling

Responsibilities of the Chiefs of the Clinical Services include:

A. Ensuring the quality of patient care rendered by their service and maintaining professional standards of behavior among Members and Affiliated Professionals (Practitioners) of their service. Academic performance or University employment are University matters and City employment is a City matter, and those matters are not addressed in these Bylaws.

B. Quality of Patient Care - Education, Monitoring and Investigation and Response to Concerns Identified.

C. Carrying out peer review and quality improvement functions for their service. The Chief of Service may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the Practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. The Practitioner will be given an opportunity to respond in writing and to discuss the matter with the Chief of Service. The Chief of Service will maintain documentation of any informal actions, monitoring, or counseling.

6.1.2. Focused Professional Practice Evaluation

A. The Focused Professional Practice Evaluation (FPPE) is a process required by the Joint Commission for evaluation by the Medical Staff of the privilege-specific competence of the provider who does not have documented evidence of competently performing the requested privilege(s) at the Hospital, whether at the time of application or on reappointment. Per the Joint Commission, this process may also be used when a question arises of a currently-privileged provider's ability to provide safe, high quality patient care. The FPPE occurs for a limited time period during which the Medical Staff evaluates the provider's professional performance. There are two types of FPPE: Proctoring FPPE and Secondary FPPE. [

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B. Proctoring, which is outlined in Section 5.6 above, is Initial FPPE. Proctoring FPPE is required for all new privileges and standardized procedures. This includes privileges and standardized procedures requested by new applicants and all newly-requested privileges and standardized procedures for existing providers. There is no exemption based on board certification, documented experience, or reputation. A Provisional Medical Staff Member or Affiliated Professional who is undergoing Proctoring FPPE will remain in provisional status until the Proctoring FPPE is completed successfully.

C. Secondary FPPE, the second type of FPPE, is required when an issue regarding patient care or any other clinical or practice concern by a Practitioner is identified and requires more than a verbal warning but does not rise to the level of a corrective action investigation.

D. The outcome of each type of FPPE must be documented as outlined in subsection 5.6.1 above.

E. In addition, Secondary FPPE will always include a written summary submitted to the Credentials Committee at the time the issue is identified and the Secondary FPPE period begins. This written summary will include: the issue identified; a description of the counseling and/or training used; the method of monitoring; a target date for closure; and a final outcome/metric to be achieved for successful completion of the Secondary FPPE. At the target date for closure the assigned Proctor will submit a report to the Credentials Committee to determine closure or the need for continued monitoring. The Credentials Committee has sole power to determine whether the Secondary FPPE has been successfully completed, to extend the Secondary FPPE, or to recommend other appropriate action. Other Corrective Action may be initiated as otherwise outlined in this Article 6.

F. Although Initial and Secondary FPPE are focused on education and improvement, any issues addressed during either type of FPPE, including but not limited to recurring issues and the failure to successfully complete Secondary FPPE, can be considered progressive steps in the Medical Staff's efforts to address performance, clinical quality, professionalism, and other issues. Information obtained from the FPPE process may also be shared with the Quality Management Department for process improvement purposes while maintaining confidentiality of the information. Such information may also be shared with UCSF (for UCSF employees) or City Human Resources (for City employees), as appropriate, when a problem warrants a separate investigation for potential discipline.

6.1.3. Ongoing Professional Practice Evaluation (Maintaining Privileges)

A. The Ongoing Professional Practice Evaluation (OPPE) is a process required by the Joint Commission regarding maintaining privileges of the Medical Staff at the Hospital and serves as an ongoing monitoring system for competence and professionalism of individual Medical Staff Members and Affiliated Professionals (Practitioners). Each Practitioner will be reviewed in their respective department on a periodic basis. Per the Joint Commission, this process involves identification of professional practice trends that impact quality of care and patient safety, and such identification may require intervention

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by the Medical Staff. The Joint Commission standard lists criteria that may be considered during the OPPE and possible sources of information.

B. The OPPE process occurs on the schedule maintained by the Credentials Committee in coordination with the MSSD. The OPPE process will always include a written summary submitted by the department to the Credentials Committee to include: the OPPE plan for the department; a description of the metrics selected by the department for the review; the method of monitoring; and a final outcome/metric to be achieved for successful completion of the OPPE. At the target date for closure the department will submit a report to the Credentials Committee regarding the outcome of the review. The Credentials Committee has sole power to determine whether the OPPE has been successfully completed, to extend the OPPE, or to recommend other appropriate action regarding any Practitioner who fails to show appropriate competencies. Moreover, two consecutive unsatisfactory or three consecutive marginal ratings in any metric will always require the department to initiate an FPPE.

C. Information obtained from the OPPE process may be shared with the Quality Management Department for process improvement purposes while maintaining confidentiality of the information.

D. If there is uncertainty regarding the Practioner's professional performance, the Medical Staff should refer the issue for further evaluation of the Practitioner under these Bylaws.

6.2. Professional Standards of Behavior

6.2.1. Professional Conduct

The Chiefs of Clinical Services are responsible for monitoring the professional behavior of Practitioners of their service and addressing inappropriate behaviors as described in the Hospital institution-wide Code of Professional Conduct Policy.

Expected behaviors of Members of the Medical Staff and Affiliated Professionals:

A. All Members and Affiliated Professionals are expected to practice with professionalism and respect towards patients, colleagues, and others, including ensuring a high quality of services rendered and that care meets professional expectations. All Practitioners are expected to maintain professional communication and confidentiality, and to promptly address improvement expectations communicated through Medical Staff, human resources, or other avenues.

B. Examples of inappropriate behaviors include, but are not limited to, the following:

1) Shouting or using vituperative language;
2) Use of profanity directed at an individual;
3) Slamming or throwing objects;
4) Physical or verbal intimidation, harassment and/or violence;
5) Hostile, condemning, or demeaning communications;
6) Derisive, insulting, or demeaning criticism of performance;

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7) Deliberate failure to abide by Hospital, Medical Staff, departmental or committee bylaws, policies and procedures, or directives, including but not limited to, refusal to comply with required duties;

8) Behavior inappropriate to the delivery of quality patient care; and

9) Retaliation against any person who addresses or reports incidents of unacceptable behavior.

Expressing contrary opinions is not disruptive conduct, nor is expressing concern regarding constructive criticism of existing policies or procedures or questioning potentially unacceptable performance or conditions, if it is done in good faith, in an appropriate time, place and manner, and with the aim of improving the environment of care rather than personally attacking any individual.

6.2.2. Investigation in Response to Alleged Inappropriate Behavior

A. Alleged violations of these Bylaws, other relevant policies, or the Code of Professional Conduct may be reported by any Hospital personnel using the confidential and Evidence Code §1157-protected Safety And Feedback Events (SAFE) reporting form maintained by the Quality Management Department and designed for this purpose, or reported in writing to a direct supervisor, the Chief of Service, or the Chief of Staff. Confidentiality will be maintained throughout the investigation of the alleged behavior and for any counseling, warning, or disciplinary action resulting from the investigation. The Chief of Service or designee will inform the person allegedly demonstrating inappropriate behavior of the report, and that person will have the opportunity to respond to or refute the allegations. If the investigation finds that the allegation does not meet the level of inappropriate behavior in violation of these Bylaws, applicable policies, or the Code of Professional Conduct, the report will be closed and dismissed. Dismissed reports will not be considered in determinations of recurrent inappropriate behaviors.

B. The Chief of Service will conduct an initial investigation within one (1) week of becoming aware of the issue. When the Chief of Service is the subject of the alleged behavior, the Chief of Staff will conduct the investigation. The Chief of Service may discuss the event with the affected Member or Affiliated Professional. The Chief of Service or Chief of Staff will take appropriate action based on the following guidelines:

1) Dismissed/No Action: The alleged behavior does not meet the level of inappropriate behavior in violation of these Bylaws, applicable policies, or the Code of Professional Conduct. The Chief of Service will report this outcome to Risk Management, including a brief explanation of why the alleged behavior did not meet the level of inappropriate behavior. The UO report will be recorded as "dismissed." No further action will be taken.

2) Meeting for Resolution: The behavior is relatively minor, had low potential to adversely affect patient care, and likely can be resolved by a meeting of the

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involved parties. The Chief of Service may convene and facilitate a face-to-face meeting for resolution between the Member or Affiliated Professional (Practitioner) and the affected party. The Chief of Staff may help identify an alternative facilitator/mediator upon request. The Chief of Service will notify Risk Management of the outcome of the Meeting for Resolution.

3) Verbal Counseling: The behavior had the potential to adversely affect patient care and is a first confirmed inappropriate behavior event for the Practitioner. The Chief of Service will verbally counsel the Practitioner when an instance of inappropriate behavior warrants such counseling. The verbal counseling will emphasize the particular conduct that is inappropriate and stress that future similar conduct may result in more formal action under the Corrective Action procedures or as allowed by these Bylaws. The Chief of Service will create a written record of the verbal counseling, including the expectations, action plan, and consequences of repeat behavior of a similar nature (which will include written counseling) communicated to the Practitioner. A Practitioner also may be directed by the Chief of Service to issue an apology to the involved party or parties. The Chief of Service will maintain documentation of the counseling and notify Risk Management of this outcome.

4) Written Counseling: The behavior had the potential to adversely affect patient care and is sufficiently serious to make verbal counseling insufficient or inappropriate, or it represents recurrent inappropriate behavior that previously was addressed with verbal counseling. The Chief of Service will meet with the Practitioner and write a formal letter that sets forth the serious nature of the inappropriate behavior, reiterates any previous verbal counseling in relation to similar inappropriate behavior exhibited by the Practitioner, emphasizes the responsibility of Practitioners to treat all persons at the Hospital courteously, respectfully, and with dignity, and informs the Practitioner that future similar conduct may result in referral of the matter to the MEC for possible Corrective Action. The letter will include expectations, the action plan, and the consequences of repeat behavior of a similar nature. The Chief of Service may also direct the Practitioner to issue an apology to the involved party or parties. The Chief of Service will send a copy of the written counseling to the Chief of Staff, the Vice Dean, and the MSSD for inclusion in the Practitioner's peer review (credentials) file. The Practitioner may submit a letter of rebuttal that will be placed in the Practitioner's peer review file. The Chief of Service will report this outcome to Hospital and UCSF ZSFG Risk Management.

5) Action Plans may include remedial education, referral for psychological evaluation and treatment, referral for anger management counseling, or other professional assistance programs. The Chief of Service is encouraged to consult with the Chief of Staff, Vice Dean, Chief Medical Officer and/or Chief Executive Officer in determining the appropriate plan of action. The Chief of Service, in consultation with the Chief of Staff, Vice Dean, Chief Medical Officer and/or Chief Executive Officer as appropriate, may revise the level of action after further information is obtained in the course of investigation and counseling.

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6) Reporting: The Chief of Staff will report aggregate data on Code of Professional Conduct issues to the MEC no less than annually. The identity of individual Practitioners will not be disclosed in these reports.

7) Progressive Discipline: While, in general, progressive corrective action interventions are appropriate, there is no prescribed number or order of corrective interventions to address remediation. The choice of corrective action intervention is left to the determination of the Chief of Service or Chief of Staff.

6.2.3. Medical Executive Committee Approval is not Required and Procedural Rights are not Triggered

The approval of the MEC is not required for actions taken by the Chiefs of Service as set forth in Section 6.2 of these Bylaws, nor do such actions give rise to procedural rights for the Practitioner as set forth in Article 7 herein.

6.3. **Corrective Action Investigations**

6.3.1. Criteria for Initiation of Corrective Action

A corrective action investigation may be initiated whenever reliable information indicates that a Practitioner may have exhibited acts, demeanor, or conduct, either within or outside of the Hospital, that are reasonably likely to be any of the following:

C. Detrimental to patient safety or to the delivery of quality patient care within the Hospital;

D. Unethical;

E. Contrary to these Bylaws and/or the Medical Staff Rules and Regulations;

F. Below applicable professional standards;

G. Detrimental to Medical Staff or Hospital operations; and/or

H. Inappropriate behavior of sufficient seriousness or a documented pattern of inappropriate behavior as defined as more than two (2) incidents warranting verbal or written counseling within a two (2) year period or more than two (2) incidents .

6.3.2. Initiation of Corrective Action

A. Any person who believes that corrective action may be warranted may provide information to the Chief of Staff, any other Medical Staff officer, any Chief of Service, the Governing Body, or the Chief Executive Officer.

B. If the Chief of Staff, any other Medical Staff officer, any Chief of Service, the Governing Body, or the Chief Executive Officer determines that Corrective Action may be warranted under this Article 6, of these Bylaws, that person or entity may request the initiation of a formal Corrective Action Investigation or may recommend particular Corrective Action. Such requests must be conveyed to the MEC in writing. The MEC may conduct an informal review of the matter to determine whether an investigation is warranted.

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C. The Chief of Staff will notify the Chief Executive Officer and the MEC and will continue to keep them fully informed of all action taken. In addition, the Chief of Staff will promptly forward all necessary information to the committee or person that will conduct any Investigation, as that term is defined in subsection 6.3.3.

6.3.3. Formal Investigation

A. If the MEC concludes that a formal investigation (an "Investigation") is warranted, it will direct an Investigation to be undertaken. The MEC may conduct the Investigation itself, may assign the Investigation to an officer of the Medical Staff or a standing committee of the Medical Staff, or may appoint an ad hoc committee to conduct the Investigation. The person or group conducting the Investigation is referred to as the "Investigator."

B. The affected Practitioner will be given an opportunity for an interview during the course of the Investigation to discuss or refute the charges or, in the discretion of the Investigator, to otherwise provide input regarding the Investigation. Such an interview does not constitute a "hearing" as the term is used in Article 7 of these Bylaws, and none of the procedural rights under Article 7 of these Bylaws will apply to the interview or the Investigation.

C. The Investigation will proceed in a prompt manner, and the Investigator must maintain a written record of its proceedings.

D. The Investigator must determine whether the Practitioner has provided a quality of care or professionalism that, in its unbiased and good faith determination, is consistent with the expectations for Practitioners.

E. The Investigator must forward a written report of the Investigation to the MEC within fifteen (15) days of completion of the Investigation. The report must include findings of fact and recommendations for appropriate corrective action, if any. The deadline for submission of the written report may be extended by the MEC for good cause.

F. If the MEC concludes action is indicated, but no further Investigation is necessary, it must proceed to take action.

6.4. Corrective Action

6.4.1. Medical Executive Committee Action

Within fifteen (15) days of receipt of the written report of the Investigation, the MEC will take action that may include, without limitation:

A. Determining that additional information is needed, in which case MEC will direct how that information will be obtained for consideration by the Investigator or MEC.

B. Determining no corrective action be taken. If the MEC determines there was no credible evidence for the complaint, any adverse information included in the complaint must be removed from the Practitioner's credentials file.

C. Deferring action for a reasonable time when circumstances warrant.

D. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein precludes department or committee chairs from issuing informal written or oral warnings outside of the mechanism for Corrective Action. In the event such letters are issued, the

affected Practitioner may provide a written response that will be placed in the Practitioner's file.

E. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff Practitionership or exercise of Clinical Privileges or Standardized Procedures, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring. *

F. Recommending reduction, modification, suspension or revocation of Clinical Privileges or Affiliate Status. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended must be stated. *

G. Recommending suspension, revocation or probation of Medical Staff membership or affiliation (i.e. revocation of Clinical Privileges or Affiliate Status, or limiting Standardized Procedures). If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended must be stated. *

H. Taking other actions deemed appropriate under the circumstances.

** Actions reported to the Practitioner's professional licensing organization (such as the Medical Board of California) and entered into the National Provider Data Bank.*

The date for taking action may be extended by the MEC for good cause.

6.4.2. Procedural Rights

A. When No Corrective Action is Required or a Letter is Issued or Non-Reportable Action is Taken

If the MEC determines that no corrective action is required, that only a letter of warning, admonition, reprimand, or censure should be issued, or that other action is to be taken that is not reportable to the Member or Affiliated Professional's professional licensing organization, the decision will be transmitted to the Governing Body. The Governing Body may affirm, reject, or modify the action. The Governing Body must give great weight to the MEC's decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the MEC, and the MEC still has not acted. The decision becomes final if the Governing Body affirms it or takes no action on it within seventy (70) days after receiving the Notice of Decision.

B. When Corrective Action Requiring a Hearing is Recommended

If the MEC recommends an action that is a ground for a hearing under Section 7.2 of these Bylaws, the Chief of Staff will give the Practitioner Notice of the adverse recommendations and of the right to request a hearing in accordance with Section 7.3 of these Bylaws. In the case of Members of the Medical Staff, the Governing Body may be informed of the recommendation, but will take no action until the Member has either waived the Member's right to a hearing or completed the hearing. Affiliated Professionals do not have the right to request a hearing per these Bylaws Section 6.2.3.

6.4.3. Initiation of Governing Body Action

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If the MEC fails to investigate or take corrective action, contrary to the weight of the evidence, the Governing Body may direct the MEC to initiate investigation or corrective action for any Member or Affiliated Professional, but only after written notice to the MEC. If the MEC fails to take action in response to the Governing Body's direction, the Governing Body may initiate investigation and corrective action, but this corrective action must comply with these Bylaws. The Governing Body must inform the MEC in writing of such action.

6.4.4. Other Action

Nothing in this Article 6 or elsewhere in these Bylaws is intended to limit the University's or City's ability to take appropriate action with respect to employment. The University and the City have their own processes for employee discipline or other issues that are separate and distinct from processes under these Bylaws. To the extent that the University or City take action against their own employees through their respective processes, such processes include appropriate due process protections.

6.5. Summary Action

6.5.1. Criteria for Initiation

A. Whenever the Member's or Affiliated Professional's conduct is such that a failure to take action may result in imminent danger to the health or safety of any individual, the Chief of Staff, the MEC, or the Chief of Service in which the Practitioner holds Privileges may summarily restrict or suspend the Medical Staff membership, Clinical Privileges, or Affiliate Status of such Practitioner.

B. Unless otherwise stated, such summary restriction or suspension ("Summary Action") becomes effective immediately upon imposition, and the person or body responsible will promptly give written notice generally describing the reasons for the action to the Practitioner, and notice to the MEC, the Chief Executive Officer, and the Governing Body.

C. The Summary Action may be limited in duration and will remain in effect for the stated period or until resolved as set forth in these Bylaws. Unless otherwise indicated by the terms of the summary action, the Chief of the involved Clinical Service will make the necessary arrangements to provide alternate coverage for proper and necessary patient care during the period of restriction or suspension.

D. The notice of the Summary Action given to the MEC constitutes a request to initiate corrective action, and the procedures set forth in Article 6 of these Bylaws must be followed.

6.5.2. Medical Executive Committee Action

The affected Member may request an interview with the MEC. The interview must be convened as soon as reasonably practicable under the circumstances but in no event less than seven (7) days after the Summary Action was taken. The interview does not constitute a hearing, as that term is used in these Bylaws, and none of the procedural rights under Article 7 of these Bylaws apply to Summary Actions. The MEC may thereafter continue, modify, or terminate the terms of the Summary Action. It will give the Member written Notice of its decision, which must include the information specified in Section 7.3 of these Bylaws if the action constitutes grounds for a hearing.

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6.5.3. Procedural Rights

Unless the MEC terminates the Summary Action, it remains in effect during the completion of the corrective action and hearing and appellate review process. When a Summary Action is continued, the affected Member is entitled to the procedural rights set forth in Article 7 these Bylaws, but the hearing may be consolidated with the hearing on any corrective action that is recommended so long as the hearing commences within forty (40) days after the hearing on the Summary Action was requested.

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6.5.4. Initiation of Corrective Action by the Governing Body

A. If no one authorized under Section 6.5 of these Bylaws is available to take a Summary Action to summarily restrict or suspend a Member's or Affiliated Professional's membership, Privileges, or Affiliate Status, the Governing Body (or its designee) may immediately suspend or restrict a Practitioner's Privileges if failure to do so may result in imminent danger to the health or safety of any individual, provided that the Governing Body (or its designee) has made reasonable attempts to contact the Chief of Staff, the MEC, and the Chief of the Service to which the Member is assigned before acting.

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B. Such Summary Action imposed under this subsection 6.5.4 is subject to ratification by the MEC. If the MEC does not ratify such Summary Action within two (2) working days of its imposition, excluding weekends and holidays, the Summary Action will terminate automatically.

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6.5.5. Reporting

When Summary Action involves summary suspension of privileges, membership, or affiliate status, the Summary Action must be reported under Section 805 of the Business and Professions Code if such Summary Action remains in effect for a period in excess of fourteen (14) days.

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6.6. Administrative Suspension of Privileges

6.6.1. Basis for Administrative Suspensions

The Chief of Staff may administratively suspend a Practitioner's Privileges or Affiliate Status for failing to complete training mandated by the hospital for regulatory purposes, failing to complete medical record documentation on a timely basis, failing to complete administrative responsibilities as required by the Chief of Service or Chief Executive Officer, and failure to obtain required health screening. Such administrative suspensions do not give rise to the due process rights of these Bylaws unless the suspension is in place for more that fourteen (14) days consecutively or thirty (30) days in a year and therefore becomes reportable to the Practitioner's professional licensing organization (such as the Medical Board).

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6.6.2. Licensure

Automatic suspension or termination of Privileges or membership, or affiliate status may occur as described:

A. Whenever a Practitioner's license or other legal credential authorizing practice in this state is revoked, limited, suspended, or expires, the Practitioner's Medical Staff membership, Privileges, or Affiliate Status are automatically suspended as of the date such action or expiration becomes effective. Renewal of a Practitioner's license or other

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legal credential authorizing practice is the sole responsibility of the Practitioner. Any notices of upcoming license renewal deadlines provided by the Hospital are a courtesy, and the failure of a Practitioner to receive or review such notices does not excuse a lapsed license or legal credential.

B. Whenever a Practitioner's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any Privileges or Affiliate Status that are within the scope of such limitation or restriction are automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

C. Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, the Practitioner's membership status and Privileges or Affiliate Status automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

D. Whenever a Practitioner's professional liability insurance required by subsection 2.2.4 lapses, the Practitioner's Medical Staff membership and Privileges or Affiliate Status are automatically suspended as of the date such lapse becomes effective shall remain suspended until adequate evidence of insurance is provided. If the Practitioner fails to provide adequate evidence of insurance within six (6) months, it is deemed as a voluntary resignation from the Medical Staff.

E. If the employment of a Practitioner who is a City employee is terminated or suspended by the City or the employee resigns, the Practitioner's Medical Staff membership and Privileges or Affiliate Status are automatically terminated or suspended, respectively, on the date such employment action becomes effective. If the employment or contractual relationship of a Practitioner who is a UCSF employee or contractor is terminated or suspended by UCSF or the contractor or the employee or contractor resigns, the Practitioner's Medical Staff membership and Privileges are automatically terminated or suspended, respectively, on the date such relationship change becomes effective. And if the employment or contractual relationship of a Practitioner who is a UCSF employee is transferred to another UCSF location or the Practitioner is removed by UCSF from providing patient care at the Hospital, the Practitioner's Medical Staff membership and Privileges or Affiliate Status are automatically suspended on the date such relationship change or reassignment becomes effective. This subsection E does not impose automatic suspension or termination on someone who either (i) moves employment between the City and UCSF if they are still assigned to provide patient care at the Hospital or (ii) shifts from being employed by the City or UCSF to being a volunteer at the Hospital. In either instance, the Practitioner's Medical Staff membership and Privileges or Affiliate Status may continue as allowed by these Bylaws so long as (a) the Practitioner is in good standing, (b) the Practitioner has professional liability insurance as required by subsection 2.2.4 above, and (c) the Chief of Staff approves the continuance.

F. A Practitioner's Privileges or Affiliate Status automatically suspended under this subsection 6.6.2 may be reinstated during the then-current term only upon written notice from the Chief of Staff or the Chief of Staff's designee and with consent of the Hospital Chief Executive Officer. Such reinstatement may include restrictions if imposed in accordance with Section 6.3. If the Practitioner provided patient care at the Hospital, or

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any City-affiliated institution while the Practitioner's license or credential was revoked, suspended, expired, limited, or restricted or while the Practitioner was on probation, reinstatement may not be granted until all instances of the Practitioner's patient care and billing during that time are reviewed to ensure that appropriate care was rendered, and to prevent improper billing.

6.6.3. DEA Certificate

A. Whenever a Practitioner's DEA certificate is revoked, limited, suspended, or expires, the Practitioner is automatically and correspondingly divested of the right to prescribe or supervise prescription of medications covered by the certificate as of the date such action becomes effective throughout its term. The Practitioner must immediately notify the MSSD of any such revocation, limitation, suspension, or expiration.

B. Whenever a Practitioner's DEA certificate is subject to probation, the Practitioner's right to prescribe such medications is automatically subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

6.6.4. Medical Records

Practitioners are required to complete medical records within the time prescribed by the MEC. Failure to timely complete medical records results in an automatic suspension after notice is given. Such suspension applies to the Practitioner's right to admit, treat, or provide services to patients in the inpatient or outpatient settings. The suspension will continue until the Practitioner completes the records at issue and any related concerns are resolved.

6.6.5. Procedural Rights

Practitioners whose Privileges are automatically suspended and/or who have been deemed to have automatically resigned the Practitioner's Medical Staff membership are entitled to the procedural rights set forth in Article 7 of these Bylaws only if the suspension or resignation is reported pursuant to California Business and Professions Code Section 805.

6.6.6. Notice of Administrative Suspension and Transfer of Patients

Notice of an automatic suspension must be given to the Practitioner and to the appropriate Chief of Service, and patients affected by an automatic suspension will be assigned to another Practitioner of the Clinical Service.

6.6.7. Automatic Termination

If a Practitioner is administratively suspended for more than three (3) months, the Practitioner's membership or Affiliate Status is automatically terminated. Thereafter, reinstatement to the Medical Staff requires application and compliance with the appointment applicable to new Applicants.

ARTICLE 7. HEARINGS AND APPELLATE REVIEWS

7.1. General Provisions

Except as otherwise provided in these Bylaws, the following definitions and rules apply under this Article.

A. "Respondent" refers to the MEC in all cases when the MEC or authorized Medical Staff officers, Members, or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Governing Body in all cases where the Governing Body or its authorized officers, directors, or committees took the action or rendered the decision which resulted in a hearing being requested.

B. "Party" and "Parties" refer to the Petitioner and Respondent, individually (Party) or collectively (Parties).

C. "Petitioner" refers to the Member who requested a hearing pursuant to subsection 7.3.2 of these Bylaws.

D. Technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws are not grounds for invalidating the action taken.

E. If an adverse action described in subsection 7.2.1 of these Bylaws is taken or recommended, the Petitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

7.2. Hearings

7.2.1. Grounds for Hearings

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions regarding a Member of the Medical Staff is deemed an actual or potential adverse action and constitutes grounds for a hearing:

A. Denial of Medical Staff appointment, reappointment, or Privileges;

B. Revocation, suspension, restriction, or involuntary reduction of Medical Staff membership and/or Privileges;

C. Involuntary imposition of significant consultation or proctoring outside of the FPPE process; or

D. Any other corrective action or recommendation that must be reported to the Member's professional licensing organization (such as the Medical Board) pursuant to California Business and Professions Code Section 805.

7.2.2. Termination from Medical Staff

Removal from a position as Chief of a Clinical Services or as an Officer of the Medical Staff, termination from the Medical Staff following two (2) years of inactive status, or termination from the Medical Staff following a resignation or lay off from employment with the University or the City, **does not** constitute grounds for a hearing.

7.2.3. Actions Taken Against Affiliated Professionals

Affiliated Professionals are subject to corrective action processes pursuant to their employer's policies and procedures or through other contractual arrangements. Notwithstanding

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The Medical Staff has authority, as outlined by these Bylaws, to consider whether to revoke, suspend, or restrict Privileges conferred by these Bylaws based on the conduct of a Member or Affiliated Professional. Actions, either direct or indirect, taken by the Director of Health, or the Director of Health's designee, pursuant to the Director's administrative authority, DPH policies, or Hospital policies Section 6.2.1.C, are not subject to hearing under these Bylaws only for the purpose of determining whether to revoke, suspend, or restrict Privileges conferred by these Bylaws.
As described in the DPH policy titled "Limiting Access to DPH Systems and Facilities," the Director of Health, or the Director of Health's designee, may restrict a Member's access to Hospital infrastructure, facilities, or systems in instances involving violations of federal, state, or local laws, or Hospital rules, regulations, or policies that are not primarily related to quality of patient care, including but not limited to any violation of patient confidentiality laws, regulations, or policies. The Director of Health or the Director of Health's designee may restrict, suspend, or permanently revoke access to patient health records kept or maintained by the City and/or to physical locations (the Hospital, clinics, or other buildings owned or operated by the City) in this manner. The approval of the MEC is not required for such actions.

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the foregoing, clinical privileges or standardized procedures exercised by Affiliated Professionals are subject to oversight by the Medical Staff. Any performance concerns or problems with clinical care related to Affiliated Professionals that are addressed by the Medical Staff, which will occur in consultation with the City Attorney's Office serving as counsel to the Medical Staff, may result in clinical privilege or Affiliate Status restriction, suspension, or termination by the Medical Staff, including pursuant to the following:

A. The Chief of Staff or the Chief of Staff's designee will determine how the issue is investigated. The Chief of Staff may appoint an *ad hoc committee* to investigate or advise the Chief of Staff and MEC. Any investigation should include an interview of the Affiliated Professional. Prior to the Medical Staff's restriction, suspension, or termination of Clinical Privileges or Affiliate Status of an Affiliated Professional, the affected Affiliated Professional will be given notice of the proposed action and afforded an opportunity to submit a written rebuttal to the Chief of Staff or the Chief of Staff's designee. The Chief of Staff or the Chief of Staff's designee in consultation with the MEC is authorized to make a recommendation on behalf of the Medical Staff and will do so in consultation with the City Attorney's Office. Notice of the decision will be given to the Affiliated Professional.

B. The Chief of Staff or Chief of Staff's designee will inform the Governing Body of any recommendation that involves the restriction or suspension of Clinical Privileges or Affiliate Status of an Affiliated Professional for a cumulative total of thirty (30) days or more in any twelve (12)-month period or termination of such privileges. Prior to informing the Governing Body of the recommended restriction, suspension, or termination of Clinical Privileges or Affiliate Status of an Affiliated Professional, the affected Affiliated Professional will be given notice of the proposed action and afforded an opportunity to submit a written rebuttal to the Governing Body. The subsequent decision of the Governing Body is final.

C. This subsection 7.2.3 does not afford an Affiliated Professional a right to a hearing under Sections 7.3 and 7.4 of these Bylaws.

7.3. Requests for Hearing

7.3.1. Notice of Proposed Action

The Medical Staff Member Petitioner must be notified in writing (by "Notice") of any recommendations that would constitute grounds for a hearing. The Notice must inform the Petitioner of the following:

A. What action has been proposed against the Petitioner;

B. Whether the action, if finally adopted, will be reported to the Member's professional licensing organization (such as the Medical Board) under California Business and Professions Code Section 805 and to the National Practitioner Data Bank;

C. The reasons for the proposed action;

D. That the Petitioner may request a hearing;

E. That a hearing must be requested within twenty (20) days; and

F. That the Petitioner has the hearing rights described in the Medical Staff Bylaws.

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7.3.2. Request for Hearing; Waiver and Consideration of Waived Hearing by the Governing Body

The Petitioner has twenty (20) days following receipt of Notice of such recommendation to request a hearing. The hearing request must be in writing, must be communicated at minimum by electronic mail, and must be addressed to the Chief of Staff with a copy to the Chief Executive Officer. The Petitioner must state, in writing, the Petitioner's intentions with respect to attorney representation during the hearing process at the time the Petitioner sends the request for a hearing.

If the Petitioner does not request a hearing within the time and in the manner described, the Petitioner will be deemed to have waived any right to a hearing and accepted the recommendation involved. Such final recommendation, based on a waiver of the right to hearing, will be considered by the Governing Body for ratification within seventy (70) days. The Governing Body must consider such final recommendation, but the recommendation is not binding on the Governing Body, which will exercise its independent authority to render a final decision on the matter.

7.3.3. Hearings Prompted by Governing Body Action

If the hearing is based upon an adverse action by the Governing Body, the President of the Governing Body or the President's designee will fulfill the functions assigned in this Section to the Chief of Staff. In such instances, the term "recommendation" used in this Section 7.3 includes any action by the Governing Body.

7.3.4. Time and Place for Hearing

Upon receipt of a timely request for a hearing made by the Petitioner, the Chief of Staff will notify the Chief Executive Officer and the MEC, appoint a Judicial Review Committee, and schedule a hearing before the Judicial Review Committee. The Chief of Staff will give notice of the hearing within twenty (20) days after receipt of the request. The notice must state the time, place, and date of the hearing. The date of the commencement of the hearing will be within twenty (20) to forty (40) days from the date the Chief of Staff received the hearing request. The date of commencement for the hearing may be extended by the Chief of Staff for good cause in the Chief's sole discretion.

7.3.5. Notice of Charges

As part of, or together with, the notice of place, time, and date of the hearing, the Chief of Staff must state in writing the reasons for the recommendation, the acts or omissions with which the Petitioner is charged, and a list of the medical records in question, when applicable. The Petitioner must be provided with a summary of the rights to which the Petitioner is entitled at the hearing. A supplemental notice of charges may be issued at any time, provided the Petitioner is given sufficient time (at least seven days) to prepare.

7.3.6. Judicial Review Committee

The Chief of Staff will appoint a Judicial Review Committee composed of not fewer than three (3) Members of the Active Medical Staff (Active Members) who will gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact finder, initial decision-maker, or otherwise actively participated in the consideration of the matter

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leading up to the recommendation. The Judicial Review Committee may have any number of members or alternates as determined by the Chief of Staff. The Chief of Staff will appoint one of these Active Members to serve as Chair. Knowledge of the matter involved does not preclude a Member from serving as a member of the Judicial Review Committee. In the event it is not possible to appoint all Judicial Review Committee members from the Active Medical Staff, the Chief of Staff may appoint any Member of the Medical Staff or other people affiliated with DPH. When feasible, the Judicial Review Committee will include at least one (1) Member who practices in the same specialty as a Petitioner and will include at least one (1) Member who is a UCSF employee and one (1) Member who is an SDPH employee. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Judicial Review Committee member becomes unavailable. Voir dire is expressly allowed, and it is to be conducted via written questions for the JRC members and the Hearing Officer. The parties will submit questions to the Hearing Officer, who will make a decision on which questions to allow. The Hearing Officer may include their own questions. The written answers to the voir dire questions will be submitted to both sides and to the Hearing Officer, and the Hearing Officer makes any final decision on challenges to participation

The proceedings and/or deliberations of the hearing will continue so long as three members of the Judicial Review Committee are present.

7.4. The Hearing Procedure

7.4.1. The Hearing Officer

The Chief of Staff will appoint a Hearing Officer to preside at the hearing. The Hearing Officer must be an attorney-at-law qualified to preside over a quasi-judicial hearing; however, an attorney regularly utilized by the Hospital for legal advice regarding its affairs and activities is not eligible to serve as Hearing Officer. The Hearing Officer must not be biased for or against any Party, must not gain any direct financial benefit from the outcome, and must not act as a prosecuting officer or as an advocate. The Hearing Officer must endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard, to assure that all participants present relevant oral and documentary evidence in an efficient and expeditious manner, and to maintain proper decorum. The Hearing Officer will determine the order of, or procedure for, presenting evidence and arguments during the hearing and has authority and discretion to make all rulings on questions that pertain to matters of law, procedure, or the admissibility of evidence that are raised prior to, during, or after the hearing, including deciding when evidence may not be introduced, granting continuances, ruling on disputed discovery requests, and ruling on challenges to Judicial Review Committee Members or the Hearing Officer serving as the Hearing Officer. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as may be warranted by the circumstances. The Hearing Officer will participate in the deliberations of the Judicial Review Committee and be a legal advisor to it, but the Hearing Officer does not have a vote on the Judicial Review Committee.

7.4.2. The Chairperson of the Judicial Review Committee

The Chief of Staff will appoint the chairperson for the Judicial Review Committee. The chairperson will serve as a liaison between the Hearing Officer and the Judicial Review

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Committee. The chairperson will take votes on issues to be decided by the JRC. The vote can be done in person, via telephone, via email, or through other methods. Any decision by the JRC shall be reported to the parties in terms of the numbers voting for and against each decision or outcome

7.4.3. Hearing Logistics

The hearing may take place in person, by videoconference, or in hybrid format, at the discretion of the Judicial Review Committee in consultation with the Hearing Officer.

The Judicial Review Committee will decide how it wants to structure the hearing, such as how many days of hearing to provide, how long each session will be, when it will start and stop sessions, etc.

If any members of the Judicial Review Committee cannot attend a session, the Judicial Review Committee will decide whether to allow the session to be recorded by video and to have the absent Committee members then watch the video after the session.

The JRC will decide how it wants to structure the hearing, such as how many days of hearing to provide, how long each session will be, when it will start and stop sessions, etc.

If any members of the JRC cannot attend a session, the JRC will decide whether to allow the session to be recorded by video and to have the absent JRC members then watch the video after the session.

The JRC itself, and not the Hearing Officer, will decide how much time to allot to the hearing, providing each side at least five hours to present its case. It is solely within the JRC's discretion to allow for additional time. The JRC may place reasonable limits on the amount of testimony or argument it wants to allow, bearing in mind the fact that written evidence in most situations is deemed admitted.

The JRC should review all non-repetitive written evidence submitted prior to making its decision.

The JRC members may ask questions of witnesses directly, preferably saving their questions for a natural pause or break in the testimony.

For most witnesses, each side must examine the witness on all relevant topics when that witness is first called to testify (extending from session to session as appropriate). This is to minimize disruption to the witnesses called to testify. Only in extreme situations and for good cause will the Hearing Officer allow a witness to be recalled to testify after each side has had a chance to examine the witness.

The JRC has authority to limit or exclude testimony of any witness based on argument by a party that the testimony is not relevant or is unnecessary. Any JRC member may make such a motion on their own, and the JRC may vote on that motion as with any other argument.

The JRC is to meet alone with the Hearing Officer after it receives the written evidence, statement of the applicable legal standard, and written summaries of the case and before the hearing commences. During that meeting the JRC may discuss any questions or has or ideas about structuring or limiting the scope or structure of the hearing. This meeting is not to be transcribed, but the JRC, working with the Hearing Officer, will provide each side with the rules

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it has adopted about how the matter will proceed and a written statement of any other limits it puts on the hearing process.

7.4.4. Representation

A. The Petitioner is entitled, at the Petitioner's own expense, to be represented at the hearing by an attorney-at-law or by a physician licensed to practice in the State of California. If the Petitioner is represented by legal counsel, the MEC may also be represented by legal counsel. The MEC may not be represented by legal counsel if the Petitioner is not so represented. If the Petitioner elects not to be represented by an attorney at the hearing, the MEC will appoint a representative from the Active Medical Staff to present the recommendation and supporting evidence and to examine witnesses. Notwithstanding the foregoing and regardless of whether the Petitioner elects to have attorney representation at the hearing, the Parties have the right to consult with legal counsel to prepare for a hearing or an appellate review.

B. When Petitioner is represented by legal counsel, the Judicial Review Committee will determine the role of legal counsel at the hearing. The Judicial Review Committee may eject any legal counsel whose activities at the hearing are, in the judgment of the Judicial Review Committee, disruptive to the proper conduct of the hearing proceedings.

C. The Hearing Officer has discretion to limit the role of attorneys to advising the attorney's clients rather than presenting the case.

7.4.5. Postponements and Extensions

Postponements and extensions of the time limits beyond those listed in these Bylaws may be requested by anyone, may be granted by the Hearing Officer on a showing of good cause, and will be granted upon mutual agreement of the Parties and the Judicial Review Committee.

7.4.6. Failure to Appear or Proceed

Failure without good cause of the Petitioner to personally attend and proceed at a hearing in an efficient and orderly manner constitutes voluntary acceptance of the recommendations involved, and such recommendations will be forwarded to the Governing Body immediately for adoption in that event.

7.4.7. Discovery

A. Pre-hearing Documentation Review Expectation

The Judicial Review Committee will be provided a summative report of the investigatory and disciplinary actions taken to date on the matter being considered. Specifically, these should include at a minimum, the following documents: the investigatory committee report including findings and recommendations that were submitted to MEC, the motion and final MEC recommendation to the Governing Body, and any statements submitted by the Medical Staff member /Petitioner in participation of the investigatory committee process or in response to MEC action.

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The parties may submit a written summary of the case not to exceed 5 single-spaced pages 15 days prior to the hearing to the Hearing Officer and the JRC members. The written summary may reference information that party plans to show through evidence and testimony. But not more than 5 pages may be submitted (e.g., no exhibits or attachments).

No less than 15 days before the start of the hearing, the JRC is to be given the recommendation of MEC in its entirety. The JRC is to be advised that the MEC recommendation is just a recommendation and that the JRC is charged with making a final decision on the issue. If the Member submitted any written rebuttal or response to the MEC recommendation prior to requesting a hearing, that written rebuttal or response is also to be provided to the JRC in the same timeframe.

Written evidence (the exhibits for each side) is to be exchanged between the parties and submitted to the Hearing Officer and the JRC 15 days prior to the start of the hearing. Exhibits must be marked sequentially with letters for the Member requesting the hearing and numbers for MEC. Each page of the written evidence should be marked with sequential numbering (Bates numbering) with a different prefix identifying which side originally provide the record.

All documents that are kept in the ordinary course of business—including but not limited to medical records, policies, emails, reports, Medical Staff Office files, a person's Medical Staff credentialing and privileges file, OPPEs/FPPEs, any written reports or summaries of the investigation leading to the hearing, and human resources files—are automatically admitted into evidence for consideration by the JRC. If a party has an objection to consideration of such written evidence, the objection must be made in writing, must be specific to any document listing the reasons for the objection, and must be provided to the Hearing Officer at least 5 days prior to the hearing. The Hearing Officer will rule on any objections, bearing in mind that the rules of evidence do not apply to the hearing and that in most situations the proper way to challenge evidence is for a party to argue about the weight, if any, the JRC should assign to the evidence. Only extreme cases—such as submission of privileged, attorney-client protected information or submission of evidence that is demonstrably false from an assessment of the context—support a decision by the Hearing Officer sustaining an objection. If an objection to a document is upheld by the Hearing Officer, the document or the aspect of the document that was objected to, is not to be considered by the JRC. Each side has the right during the hearing to comment on whether exhibits are reliable and what weight to give each exhibit. For sake of clarity, time during the hearing should not be spent arguing objections based on the rules of evidence because the rules of evidence do not apply and because the JRC is sophisticated and can be reminded of its duty to make a judgement about what weight to give evidence.

B. Legal Standard

A proposed statement of the legal standard applicable to the hearing is to be submitted to the Hearing Officer 15 days prior to the start of the hearing. The Hearing Officer will then decide what statement of the legal standard applicable to the hearing will be provided to the JRC. The Hearing Officer may adopt any portion of the proposed written statements and/or may draft their own language. The statement of the legal standard must be provided to the JRC at least 5 days prior to the start of the hearing.

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C. Rights of Inspection and Copying

The Petitioner may inspect and copy (at the Petitioner's own expense) any documentary information relevant to the charges that the Respondent has in its possession or under its control. The Respondent may inspect and copy (at its expense) any documentary information relevant to the charges that the Petitioner has in the Petitioner's possession or under the Petitioner's control. The request for discovery must be fulfilled as soon as practicable. Failure to comply with reasonable discovery requests at least twenty (20) days prior to the hearing is good cause for a continuance of the hearing. The Petitioner may not retain or possess unredacted medical records that contain any protected health information, and any unredacted records must be kept securely during the Hearing process. Petitioner must consult with the City Attorney's Office before accessing any patient medical record for purposes of preparing for the Hearing in order to ensure compliance with state and federal privacy rules.

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D. Limits on Discovery

The Hearing Officer will rule on discovery disputes the Parties cannot resolve. Discovery may be denied when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either Party does not extend to confidential information referring solely to individually identifiable Members other than the Petitioner, nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information. Protected health information of any patient is generally not to be disclosed during discovery and may only be produced in redacted form. If the volume of materials makes redaction unfeasible, then the Judicial Review Committee must impose reasonable restrictions, in consultation with the City Attorney's Office, to ensure that protected health information is not removed from the Hospital or disclosed.

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E. Ruling on Discovery Disputes

In ruling on discovery disputes, factors that the Hearing Officer may consider include, but are not limited to, the following:

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1) Whether the information sought may be introduced to support or defend the charges;
2) Whether the information is "exculpatory" or "inculpatory" in nature;
3) The burden on the Party in possession of producing the requested information; and
4) What other discovery requests the Party has previously submitted resisted.

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7.4.8. Objections to Introduction of Evidence Previously Not Produced for the Medical Staff

The Respondent may object to the introduction of evidence that was not provided during the appointment or reappointment process or investigation of other matter at issue in the hearing. The information will be barred from the hearing by the Hearing Officer unless the Petitioner can prove the Petitioner previously acted diligently with respect to providing evidence and could not have submitted the information at issue.

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7.4.9. Pre-Hearing Document Exchange

At the request of either Party, the Parties must exchange copies of all documents that will be introduced at the hearing. The documents must be exchanged at least seven (7) days before commencement of the hearing. A failure to do so is good cause for a continuance.

7.4.10. Witness Lists

At the request of either Party, each Party must furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that Party at the hearing.

Nothing in the foregoing sentence precludes the testimony of additional witnesses whose possible participation was not reasonably anticipated. The Parties must notify each other as soon as a Party becomes aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least seven (7) days prior to the hearing date at which the witness is to appear constitutes good cause for a continuance.

7.4.11. Procedural Disputes

A. The Parties have a duty to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

B. The Parties are entitled to file motions as deemed necessary to give full effect to the rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the Judicial Review Committee. Such motions must be in writing and must specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving Party must deliver a copy of the motion to the opposing Party, who will have seven (7) days to submit a written response to the Hearing Officer, with a copy to the moving Party. The Hearing Officer will determine whether to allow oral argument on any such motions. The Hearing Officer's ruling on the motion must be in writing and will be provided to the Parties promptly. All motions, responses, and associated rulings must be entered into the hearing record by the Hearing Officer.

7.4.12. Record of Hearing

A court reporter shall be present to make a record of the hearing proceedings. The cost of a court reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the Party requesting it. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken on oath or affirmation.

7.4.13. Rights of the Parties

The Petitioner may ask the Judicial Review Committee Members and Hearing Officer questions, if reasonably relevant in the determination of the Hearing Officer, that are directly related to evaluating the impartiality of the Judicial Review Committee Members or the Hearing Officer. Challenges to the impartiality of any Judicial Review Committee Member will be ruled on by the Hearing Officer, and challenges to the impartiality of the Hearing Officer will be ruled on by the Chief of Staff in consultation with the City Attorney's Office. Both Parties may: call and examine witnesses for relevant testimony; introduce relevant exhibits or other documents;

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cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues, and otherwise rebut evidence; receive all information made available to the Judicial Review Committee; and submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner. The Petitioner may be called by the Respondent or by the Judicial Review Committee and examined as if under cross-examination. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

7.4.14. Rules of Evidence

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence do not apply to a hearing conducted under this Article. The Hearing Officer will admit, subject to subsection 7.4.1 above, for consideration any evidence, including hearsay, the Hearing Officer determines is relevant to the determination of the issues presented during the Hearing.

7.4.15. Burdens of Presenting Evidence and Proof

A. At the hearing, the Respondent has the initial duty to present evidence for each case or issue in support of its recommendation. The Petitioner may present evidence in response.

B. If the Petitioner is challenging denial of an initial application for Medical Staff membership or privileges, the Petitioner bears the burden of persuading the Judicial Review Committee, by a preponderance of the evidence (meaning that something is more likely than not to be true, based on a review of all relevant information), that the Petitioner is qualified for membership and/or the denied or restricted Privileges.

C. In relation to other recommendations, the Respondent bears the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that Respondent's recommendation is reasonable and warranted.

7.4.16. Adjournment and Conclusion

The Hearing Officer may adjourn the hearing and reconvene it at the convenience of the participants without providing any specific form of notice. Upon conclusion of the presentation of oral and written evidence, the hearing is deemed closed. The Judicial Review Committee must then, outside of the presence of any person other than the Hearing Officer, conduct its deliberations and thereafter issue a written decision and accompanying report listing the basis for the decision (the "Decision") as set forth in subsection 7.4.16 below.

7.4.17. Voting

Each decision by the JRC, including the final decision on the merits of the hearing, is to be made by majority vote, which means half of the JRC plus one vote. (If there's a tie, then the status quo can be maintained. If that's on the final MEC recommendation, you should consider if that means the recommendation is rejected.)

7.4.18. Basis for Decision

The decision of the Judicial Review Committee must be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and testimony. The Judicial Review Committee must determine whether the

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Member has provided a quality of care or professionalism that, in its unbiased and good faith determination, is consistent with the expectations for Members.

7.4.19. Decision of the Judicial Review Committee

Except as outlined below in this subsection, within twenty (20) days after final adjournment of the hearing, the Judicial Review Committee must issue the Decision. The date for issuing the Decision may be extended by the Judicial Review Committee for good cause. But if the Petitioner is currently under suspension, the time for the Decision will be twelve (12) days after final adjournment. Final adjournment is when the Judicial Review Committee has concluded its deliberations. A copy of the Decision must be sent to the Chief Executive Officer, the MEC, the Governing Body, the Petitioner, and the Petitioner's representative (if applicable). The Decision must contain the Judicial Review Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the Petitioner and the Respondent must be provided a written explanation of the procedure for appealing the Decision. The Decision of the Judicial Review Committee is considered final, subject only to such rights of appeal or Governing Body review as described in these Bylaws.

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7.5. Appeal

7.5.1. Time for Appeal

Within twenty (20) days after receipt of the decision of the Judicial Review Committee, either the Petitioner or the Respondent may request an appellate review by the Governing Body. Said request must be delivered to the Chief of Staff in writing, in person or by certified mail, and must include a brief statement as to the reasons for appeal. If such appellate review is not requested within such period, both sides are deemed to have accepted the recommendation involved, and that recommendation then becomes, pending ratification by the Governing Body, final and effective immediately.

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7.5.2. Grounds for Appeal

On appeal, the Governing Body may exercise its independent judgment in determining:

(1) whether there was substantial failure of the Judicial Review Committee to comply with the procedures required by these Bylaws so as to deny fair hearing, (2) whether the decision is reasonable and warranted, and/or (3) whether any bylaw, rule, or policy relied on by the Judicial Review Committee is unreasonably applied or interpreted.

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7.5.3. Time, Place, and Notice

In the event of an appeal to the Governing Body, the Governing Body will within thirty (30) days after receipt of such notice of appeal, schedule and arrange for an appellate review. The Governing Body will provide notice of the time, place, and date of the appellate review. The date of the appellate review must be within sixty (60) days from the date of receipt of the request for the appellate review; however, when a request for appellate review comes from a Member who is under suspension, the review must be held as soon as practical, but not to exceed thirty (30) days from the date of receipt of the request. The time for appellate review may be extended by the President of the Governing Body for good cause.

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7.5.4. Nature of Appellate Review

The proceedings of the Governing Body under Section 7.5 are in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the Governing Body may, at its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing. Each Party shall have the right to present a written statement in support of the Party's position on appeal, to personally appear and make oral argument, and to be represented by an attorney. At the conclusion of oral argument, if allowed, the Governing Body may then, at a time convenient to itself, conduct deliberations outside the presence of the Parties and each Party's representatives. The Governing Body may affirm, modify, or reverse the decision of the Judicial Review Committee or, at its discretion, refer the matter for further review and recommendation.

7.5.5. Final Decision

Within thirty (30) days after the conclusion of the proceedings before the Governing Body (including both the appellate hearing and subsequent deliberations), the Governing Body must render a final decision in writing and deliver copies of that decision to the Applicant or Member of the Medical Staff and to the Chief of Staff, in person or by certified mail.

7.5.6. Delegation to Governing Body Members on the Joint Conference Committee

Nothing herein prevents the Governing Body from delegating the appellate process to those Governing Body Members appointed to the Joint Conference Committee. In such an event, the Governing Body Members of the Joint Conference Committee must submit a written report and recommendations to the full Governing Body for approval.

7.5.7. Further Review

Unless the Governing Body refers the matter back to the Judicial Review Committee for further review and recommendations, the final decision of the Governing Body following the appeal procedures set forth in these Bylaws will be effective immediately and is not subject to further review. If the matter is referred back to the Judicial Review Committee for further review and recommendations, the Judicial Review Committee will promptly conduct its review and make its recommendations to the Governing Body. This further review process and the report back to the Governing Body must not exceed thirty (30) days except as the Parties may otherwise stipulate.

7.5.8. Right to One Hearing Only

Except as otherwise provided in these Bylaws, no Applicant or Member is entitled to more than one (1) evidentiary hearing and one (1) appellate review hearing on any matter which is the subject of an adverse recommendation.

7.5.9. Affiliated Professionals, House Staff, Medical Students, and Trainees

Affiliated Professionals, House Staff, Medical Students, and Trainees are not entitled to the procedural rights set forth in these Bylaws except as expressly listed in subsection 7.2.3 for Affiliated Professionals.

7.5.10. Denial of Applications for Failure to Meet the Minimum Qualifications

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Applicants are not entitled to the procedural rights of these Bylaws if the Applicant's membership, Privileges, applications, or requests are denied because of the Applicant's failure: to have a current California license to practice medicine, dentistry, clinical psychology, or podiatry; to maintain an unrestricted DEA certificate (when it is required under these Bylaws); to maintain professional liability insurance (as required by the Bylaws); to meet any of the other basic standards specified in Article 2 of the Bylaws; or to file a complete application.

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7.5.11. Automatic Suspension or Limitation of Privileges

A Member or Affiliated Professional is not entitled to any procedural rights when the Practitioner's license or legal credential to practice has been revoked or suspended as set forth in Article 6 of these Bylaws. In other cases described in Article 6 of these Bylaws, the issues which may be considered at a hearing, if requested, may not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the Member may continue to practice in the Hospital with those limitations imposed. Members whose Privileges are automatically suspended and/or who have resigned the Member's Medical Staff membership for failing to complete medical records or for failing to maintain malpractice insurance are not entitled under these Bylaws to any procedural rights, except when a suspension for failure to complete medical records will exceed fourteen (14) days and must be reported to the Member's professional licensing organization (such as the Medical Board) pursuant to California Business and Professions Code Section 805.

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ARTICLE 8. STRUCTURE OF THE MEDICAL STAFF

8.1. Medical Staff Year

The Medical Staff Year is July 1 through June 30.

8.2. Officers of the Medical Staff

The officers of the Medical Staff are the Chief of Staff, Chief of Staff-Elect, or, in alternate years, the Chief of Staff-Past.

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8.2.1. Qualifications of Officers

Officers must be Members of the Active Medical Staff at the time of nomination and election and must remain Members in good standing during the Member's term of office.

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8.2.2. Election of Chief of Staff-Elect

The Chief of Staff-Elect of the MEC will be elected at the Annual Meeting of the Medical Staff in alternate years for a one (1) year term unless a vacancy as described in this Article indicates a need to have an additional election to fill the positions.

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The Nominating Committee must present a candidate to the Active Medical Staff Members in attendance at the Annual Meeting of the Medical Staff. Other nominations may be taken from the floor, with the approval of the nominee, prior to the meeting.

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If floor nominations are made, a hand vote will be taken to elect the Chief of Staff-Elect. A simple majority of the Active Medical Staff Members attending the meeting will determine the election. If no floor nominations are made, a vote of acclamation will be requested by the presiding Chief of Staff.

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8.2.3. Term of Office

The Chief of Staff will serve a two (2) year term of office. The Chief of Staff-Elect will serve a one (1) year term from the beginning of the Medical Staff year and assume the responsibilities of the Chief of Staff at the end of that term. Upon completion of the two (2) year term as the Chief of Staff, the outgoing Chief of Staff will serve one (1) year as Chief of Staff-Past and be available to serve as Acting Chief of Staff in the first year of the Chief of Staff's two-year term. The Chief of Staff-Elect will be available to serve as Acting Chief of Staff in the second year of the Chief of Staff's two-year term. The standard term of office for the Chief of Staff is two (2) years. When the Nominating Committee believes continuity should be prioritized due to particular circumstances, the Chief of Staff may be re-elected to serve one (1) additional year. In the event that the Chief of Staff is re-elected, then the Chief of Staff Past will continue as an officer of the Medical Staff.

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8.2.4. Vacancies in Office

In the event of the temporary absence of the Chief of Staff, the Chief of Staff must designate a Member of the MEC or a previous Chief of Staff to serve as the acting Chief of Staff, including chairing the MEC meetings.

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If the position of the Chief of Staff becomes permanently vacant during the first year of the two (2) year term, the Chief of Staff-Past will assume all designated responsibilities through the end of the Medical Staff Year. If the Chief of Staff-Past is unable to serve, the MEC will appoint an Acting Chief of Staff who will serve through the end of the Medical Staff Year. If the vacancy occurs in the second year of the Chief of Staff's elected term, the Chief of Staff-Elect will assume the duties of the office through the end of the Medical Staff Year and then continue as the Chief of Staff for a two (2) year term.

8.2.5. Duties of Officers

A. Chief of Staff

The Chief of Staff will:

1) Serve as Chief of the Medical Staff;
2) Represent the views, policies (including strategic planning and budget considerations), needs and grievances of the Medical Staff and MEC to the Governing Body, to the Chief Executive Officer, and to the Vice Dean;
3) Receive and present to the MEC the activities of the Governing Body;
4) Report Medical Staff activities to the Governing Body;
5) Be the spokesperson for the Medical Staff and the MEC in external professional and public relations;
6) Appoint committee Chairs and approve Members to all Medical Staff committees except the MEC and Joint Conference Committee;
7) Call, preside at, and be responsible for the agenda of all regular and special meetings of the MEC and of the Medical Staff;
8) Be responsible for the enforcement of Medical Staff Bylaws and for corrective action as provided for in these Bylaws;
9) In the interim between MEC meetings, performing those responsibilities of the MEC that, in their reasonable opinion, must be accomplished prior to the next regular or special meeting of the MEC;
10) Serve as a Member of the Joint Conference Committee;
11) Serve as a Member of the Credentials Committee;
12) Preside at the Annual Meeting of the Medical Staff;
13) Serve as an interface between the Medical Staff and the leadership of the hospital; and
14) Attend any Medical Staff committee meetings as necessary and appropriate in the Chief of Staff's discretion.

B. Chief of Staff-Elect

The Chief of Staff-Elect will:

1) Perform duties as assigned by the Chief of Staff and, in the absence of the Chief of Staff, assume the duties and have the authority of the Chief of Staff.

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2) Serve as Chair of the Bylaws Committee, or co-chair the committee with the Chief of Staff;

3) Serve as a member of the Credentials Committee;

4) Serve on the MEC;

5) Beginning six (6) months prior to assuming the role of Chief of Staff, serve as a member of the Joint Conference Committee; and

6) Assume the office of Chief of Staff at the end of the current Chief of Staff's term.

C. Chief of Staff-Past

The Chief of Staff-Past will:

1) Perform duties as assigned by the Chief of Staff and assume the duties and have the authority of the Chief of Staff in the absence of the Chief of Staff;

2) Chair the Nominating Committee of the Medical Staff;

3) Serve on the MEC, Joint Conference Committee and the Credentials Committee.

8.2.6. Removal of Officers

A Medical Staff Officer may be removed from office for any valid cause including, but not limited to, failure to carry out the duties of the office, gross neglect or malfeasance in office, or serious acts of moral turpitude. Except as otherwise provided in these Bylaws, removal of Medical Staff officers may be initiated by the MEC or upon the written request of twenty percent (20%) of the Active Medical Staff. Such removal may be effected by majority vote of the MEC Members or by a two-thirds vote of the Active Medical Staff. Voting on the removal of an elected officer will be by secret written ballot.

ARTICLE 9. CLINICAL SERVICES

9.1. Organization of Clinical Services

9.1.1. Overall Supervision

Each Clinical Service will have a Chief who is responsible for the overall supervision of the clinical work, teaching, and research within that Clinical Service. Each Clinical Service may be organized into subsections.

9.1.2. Clinical Services

The Clinical Services are as follows: Anatomic Pathology, Anesthesiology and Peri-Operative Care, Community Primary Care, Oral & Maxillofacial Surgery, Dermatology, Emergency Medicine, Family and Community Medicine, Laboratory Medicine, Internal Medicine, Neurology, Neurosurgery, Obstetrics-Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology and Head & Neck Surgery, Pediatrics, Psychiatry, Radiology, Surgery, and Urology.

9.2. Qualifications, Selection and Tenure of Chiefs of Services

9.2.1. Qualifications

A. All Chiefs of Service must be board certified or re-certified in their respective specialty.

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B. Chiefs of Service must have a University faculty appointment, excepting the Chief of the Community Primary Care Service (CPC).

C. Chiefs of Service may be the Chair or Vice Chair of the Chief's respective University department.

D. Chiefs of Service must be Members of the Active Medical Staff, and Clinical Privileges will be determined as set forth in Article 6 of these Bylaws.

9.2.2. Selection of a Chief of Service

A. Upon notification that a Chief of Service will vacate the Chief of Service's position prior to the appointment of a new Chief of Service, the UCSF Department Chair and Vice Dean, in consultation with the Chief Executive Officer and Chief of Staff, will select a proposed Interim Chief of Service. After approval by MEC, the Chief of Staff will appoint the selected individual as the Interim Chief of Service.

B. Within six months of a vacancy for a Chief of Service, the Chief of Staff, in consultation with the Vice Dean, UCSF Department Chair and Chief Executive Officer, will appoint a search committee for a new Chief of Service. The search committee will be chaired by a Member of the Active Medical Staff and be composed of Members of the Active Medical Staff, University faculty, the Vice Dean or their designee, and the Hospital Chief Executive Officer or their designee. If the Department has clinically active Affiliated Professionals, at least one Affiliated Professional member of the Department will also be invited to join the search committee. The composition of the search committee will be approved by the University's Academic Affairs Office.

C. The Chief of Staff must consult with the Director of Health or designee, and the Chief Executive Officer, in appointing the ad hoc search committee for the selection of the Chief of Community Primary Care (CPC). The search committee for the Chief of CPC must be chaired by a Member of the Active Medical Staff and must include Members of the Active Medical Staff, Members of the CPC, the Director of Health or their designee, and the Chief Executive Officer or their designee, and at least one Affiliated Professional member of CPC.

D. The recommendations of the Chief of Service search committee will be made to the Chief of Staff and UCSF Department Chair who will, in consultation with the Vice Dean and Chief Executive Officer, nominate the new Chief of Service for that service. The recommendations of the search committee for the Chief of CPC will be made to the Chief of Staff who will, with the approval of the Director of Health, nominate the Chief of CPC.

E. Following recommendation of the Chief of Service candidate to the Chief of Staff and UCSF Department Chair, the UCSF Department Chair will conditionally offer the position to the Chief of Service Candidate and, in consultation with the Vice Dean, negotiate terms of the contract and support.

F. Once the candidate for Chief of Service has accepted the conditional offer, the Chief of Staff will proceed with facilitating the formal nomination process. The Chief of Service nomination will be acted upon by the MEC. Ratification of the nomination will be accomplished by a two-thirds vote and be forwarded to the Governing Body for approval.

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G. Upon approval of the Governing Body of the new Chief of Service, the nominee will assume the office of Chief of Service for that service.

H. If the MEC or Governing Body disapprove the nomination, the Chief of Staff must reconstitute an ad hoc search committee.

9.2.3. Review and Reappointment

A. Chiefs of Clinical Services must be reviewed every five (5) years or at any time as requested by the Chief of Staff, the Vice Dean, or the Chief Executive Officer. Continuation as the Chief of Service is contingent upon a favorable result of this review.

B. The review will be led by the Vice Dean and Vice Dean's Office, and the results will be discussed with the Chief of Staff and the Chief Executive Officer.

C. A summary of the review will be placed in the Chief of Service's credentials file that includes strengths/accomplishments and areas for improvement.

D. The Chief of Staff, in consultation with the Vice Dean and Chief Executive Officer, will make a recommendation regarding the reappointment of a Chief of a Clinical Service based on the review committee's findings. The reappointment requires approval by a majority vote of the MEC and the Governing Body.

9.2.4. Removal of a Chief of Service

A. Request for removal of a Chief may be initiated by:

1) A two-thirds vote that includes a combination of the Clinical Service's Active Medical Staff Members;

2) The Vice Dean, Chief Executive Officer, or Chief of Staff; or

3) By two-thirds vote of the MEC.

B. When a request for removal has been initiated, a Review Committee will be appointed by the Chief of Staff in consultation with the Vice Dean, UCSF Department Chair and the Chief Executive Officer. The findings of the Review Committee must be acted upon by the MEC.

C. The recommendation of the MEC will be forwarded to the Governing Body for approval.

9.2.5. Temporary Absence of a Chief of Service

A. When a Chief of a Clinical Service is temporarily absent from the position for more than thirty (30) days, prompt notification must be made to the Chief of Staff. Upon receipt of such notice, the Chief of Staff will appoint an Acting Chief for the Clinical Service in consultation, when feasible, with the permanent Chief of Service, the UCSF Department Chair, the Vice Dean, and the Chief Executive Officer.

B. Appointment of an Acting Chief of a Clinical Service for more than ninety (90) days requires the approval of the MEC and the Governing Body.

9.3. Functions of a Chief of Service

Each Chief will:

9.3.1. Credentialing/Privileging

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A. Recommend criteria for clinical privileges in the Clinical Service;

B. Recommend a sufficient number of qualified and competent individuals to provide care/clinical services;

C. Make reports to the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for each Applicant seeking privileges in the Clinical Service;

D. Make recommendations to the Credentials Committee regarding the qualifications and competence of Affiliated Professionals in the Clinical Service;

E. Make recommendations for granting temporary privileges; and

F. Be responsible for the evaluation of all new appointees and report thereon to the Credentials Committee.

9.3.2. Performance Improvement

A. Continuously monitor and evaluate the quality and appropriateness of patient care provided within the clinical service, including:

1) Recommend for approval by the Credentials Committee and MEC the criteria to be used in conduct of Ongoing Professional Practice Evaluation (OPPE) and conduct periodic OPPE for each Member and Affiliated Professional of the Clinical Service at an interval not to exceed twelve (12) months. Data used to complete OPPE forms will be maintained and stored in each Clinical Service for the duration of each medical staff Member's tenure, but in no event less than ten (10) years.

2) Monitor and evaluate the quality and appropriateness of patient care provided by the attending staff;

3) Monitor and evaluate the quality and appropriateness of House Staff supervision by attending staff; and

4) Monitor and evaluate the quality and appropriateness of patient care provided by House Staff.

B. Continuously monitor the professional performance of all individuals who have delineated clinical privileges or standardized procedures in the Clinical Service, and report thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;

C. Hold regular Performance Improvement Conferences no less than quarterly to present and discuss specific patient cases and best practices;

D. Appoint ad hoc committees and working groups as necessary to carry out quality improvement activities; and

E. Conduct a Focused Professional Practice Evaluation (FPPE) of any individual with privileges or standardized procedures in the Clinical Service if there is a reasonable basis to be concerned that the individual's professional qualifications, clinical ability, judgment, character, physical or mental health, professional ethics, or other matters might directly or indirectly affect patient care.

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1) The FPPE must consider the individual's overall performance as well as specific cases. Comparison with historical, departmental, and external benchmarks may be considered.

2) A peer review panel may be appointed to conduct an FPPE.

3) Recommendations from an FPPE may be used as the basis for continued routine monitoring and education or for pursuing formal corrective action.

9.3.3. Education and Research

A. Be accountable to the Vice Dean and the UCSF Department Chairs for the conduct of graduate and undergraduate medical education and UCSF based research programs conducted in the Chief's Clinical Service; and

B. Be responsible for the establishment, implementation, and effectiveness of the orientation and supervision of the teaching, education, and research programs in the Clinical Service.

9.3.4. Administration

A. Designate an Acting Chief when unavailable for more than twenty (24) hours but less than thirty (30) days and communicate the designee to the Chief of Staff and Medical Staff Office. After thirty (30) days, the process described in subsection 9.2.5 must be followed.

B. Be responsible and accountable to the Governing Body, through the Chief of Staff, for all clinically and administratively related activities within the Clinical Service;

C. Be a Member of MEC and regularly disseminate decisions made and issues discussed at MEC meetings to the Members of the Clinic Service. It is the expectation that the Chiefs of the Clinical Services will attend at least fifty percent (50%) of the MEC meetings each year and that they will send a designee when unable to attend.

D. Be responsible for the integration of the Clinical Services into the primary functions of the organization;

E. Be responsible for the coordination and integration of interdepartmental and intradepartmental services;

F. Review and update the Clinical Service Rules and Regulations at least every two years;

G. Be responsible for the orientation of new Members and for the enforcement of the Medical Staff Bylaws and Rules and Regulations and the Hospital's policies and procedures within the respective Clinical Service;

H. Ensure adequate input from the Chief's Clinical Service at Medical Staff committee meetings through attendance by service Members;

I. Be responsible for implementation within the Clinical Service of actions taken by the Governing Body and the MEC;

J. Participate in the administration of the Chief's Clinical Service through cooperation with the Nursing Service, Hospital Administration, and all personnel involved in matters affecting patient care;

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K. Report and make recommendations to Hospital Administration when necessary with respect to matters affecting patient care in the Clinical Service, including personnel, space, resources, supplies, special regulations, standing orders and techniques;

L. Be responsible for the process of assessing and recommending off-site sources that provide patient care services not available at the Hospital;

M. Assist in the preparation of annual records, including budgetary planning, pertaining to the Clinical Service as may be required by the Chief of Staff, the MEC, the Vice Dean, Chief Executive Officer, or the Governing Body;

N. Delegate to a vice chief or other Active Staff Member of the Clinical Service such duties as appropriate;

O. Establish divisions, sections, or services within the Clinical Service and appoint Chiefs thereof, subject to the approval of the MEC and the Governing Body;

P. Develop and implement policies and procedures that guide and support the provisions of services;

Q. Maintain quality improvement programs; and

R. Make a presentation to the MEC at least every two (2) years on the activities of the Clinical Service.

9.4. **Functions of Clinical Services**

S. Each Clinical Service must establish written criteria consistent with the policies of the MEC for the granting of Clinical Privileges and Standardized Procedures.

T. Each Clinical Service is responsible for maintaining and supervising a high quality education and training program for graduate and undergraduate education in the health sciences.

U. Each Clinical Service is responsible for the supervision of House Staff and the House Staff training programs.

V. The Chief of CPC will collaborate with the appropriate Chiefs of Clinical Services and the Vice Dean to maintain and supervise high quality training experiences within the CPC clinical sites for graduate and undergraduate students in the health sciences.

W. Each Clinical Service will develop criteria under which consultation will be required; these shall not preclude a requirement for consultation when the Chief of Service determines that a patient would benefit from such consultation.

X. Each Clinical Service will meet as frequently as necessary, but at least quarterly, to consider findings from the ongoing monitoring and evaluation of quality and appropriateness of the care and treatment provided to patients. Written summaries and recommendations of any and all new policies or changes in policies will be submitted to the Medical Executive Committee for its approval.

9.5. **Assignment to Clinical Service**

The MEC will, after consideration of recommendations of the Clinical Services as transmitted through the Credentials Committee, recommend initial Clinical Service assignments for all Applicants. All Medical and Affiliated Staff Members shall be assigned to at least one

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Clinical Service and be granted clinical privileges or standardized procedures that are relevant to the care provided in that Clinical Service. The exercise of clinical privileges or standardized procedures within any Clinical Service are subject to the Medical Staff Bylaws, the Rules and Regulations of that Clinical Service, and the authority of the Chief of Service.

ARTICLE 10. MEDICAL STAFF AND AFFILIATE PROFSSIONALS LEADERSHIP

10.1. Definitions of Medical Staff and Affiliate Professional Leaders (in addition to Chiefs of Service as set forth in Article 9)

The term Medical Staff and Affiliate Professional Leaders includes the following positions:

A. **Central Leadership Positions:** (1) Medical Directors or Associate Chief Medical Officers of multi-specialty service lines or (2) Medical Directors of hospital departments that pertain to multiple services. (See Appendix 3.)

Examples: 1. Medical Directors or Associate Chief Medical Officers of Critical Care, Perioperative Services, Trauma; 2. Medical Directors of Risk Management, Quality Improvement, Care Experience, Informatics, Infection Control.

B. **Service Leadership Positions:** Medical Directors or Vice Chiefs of units or services within a single Clinical Service.

Examples: Medical Directors of Family Health Center, Medicine Inpatient Services, EMS Base Station, Sleep Center, Diabetes Program, Asthma Clinic.

10.2. Qualifications of Medical Staff and Affiliated Professional Leaders

Leaders must be Members of the Active Medical or Affiliated Staff at the time of appointment and must remain Members in good standing during the Member's tenure.

10.3. Appointment of Medical Staff and Affiliated Professional Leaders

A. Central leadership positions are appointed by an open search process organized by the Chief Medical Officer or designee. The search committee is composed of clinical stakeholder leaders. The candidate selected must be approved by the Chief Medical Officer, Chief Executive Officer, and Vice Dean.

B. Service Leadership positions are appointed by the Chief of Service.

10.4. Term of Appointment

A. Central leadership positions are one (1) year appointments subject to annual review based on satisfactory performance and the needs of the Hospital. Review is performed by the Chief Medical Officer in consultation with Executive Leadership.

B. Service Leadership positions are one (1) year appointments subject to annual review based on satisfactory performance and the needs of the Hospital. Review is performed by the Chief of Service in consultation with the Chief Medical Officer.

10.5. Reporting Relationships

A. Central leadership positions report to the Chief Medical Officer.

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B. Service Leadership positions report jointly to their Chief of Service and Hospital Administration via the Chief Medical Officer for this administrative role.

10.6. Duties of Medical Staff and Affiliated Professional Leaders

A. In partnership with the Nurse dyad, the Leader is responsible for the quality of patient care, patient experience, and operational management of care provided by the clinical unit in alignment with True North goals and hospital leadership vision.

B. The central function of this position is to serve as the Leader for the clinical area, engaging front line providers to optimize operational, clinical quality, patient experience, and financial metrics. This includes meeting clinical enterprise performance and outcome benchmarks set by Hospital Administration.

C. Specific duties are detailed in the job descriptions.

10.7. Salary Support for Medical Staff and Affiliated Professional Leader Effort

A. Central leadership positions are funded via the Affiliation Agreement Central Medical Staff and Affiliated Professional Leadership account.

B. Service Leadership positions are funded by the Service.

ARTICLE 11. COMMITTEES OF THE MEDICAL STAFF

11.1. Committee Designation

Standing committees, subcommittees, and ad hoc committees of the Medical Staff described in these Bylaws and in the Committee Manual are created for and meet the purpose of peer evaluation and improvement of the quality of care rendered in the Hospital. Medical Staff functions covered by appropriate committees include, but are not limited to, executive review, credentialing, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting Medical and Affiliated Members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services.

11.2. General Provisions

11.2.1. Ad Hoc Committees

As the need arises, the Chief of Staff, with the advice and counsel of the MEC, may appoint ad hoc committees to deal with specific problems including the evaluation and improvement of the quality of care rendered in the Hospital. Each such ad hoc committee will keep permanent records of its proceedings and activities and submit a report of its activities to the MEC.

11.2.2. Parliamentary Procedure

All meetings of all committees and subcommittees of the Medical Staff are to be conducted following Robert's Rules of Order or a less formal implementation of the concepts included in Robert's Rules of Order.

11.2.3. Scheduling

Medical Staff committees will hold regular meetings as specified in these Bylaws, the meeting schedule of which will be reviewed and/or revised by the Chair at the beginning of each academic year. The committee members will be advised in writing, at least one (1) week in advance of scheduled meetings, of any necessary changes to the established meeting schedule. If no meeting schedule is otherwise described in these Bylaws, the committee will meet at least quarterly unless otherwise required in the description for each committee.

11.2.4. Appointment of Chairs of Committees

Standing committee chairs are appointed by the Chief of Staff except when chairs are specified in these Bylaws. Subcommittee chairs of standing committees are appointed by the Chairs of each respective standing committee. Standing committees of the Medical Staff are chaired only by Members of the Active Medical Staff or a voting Affiliated Professional member of the committee.

11.2.5. Committee Membership Appointment

Membership of each committee is appointed by the committee chair, after consultation with the Chief of Staff or Chief Executive Officer, as appropriate. The MSSD will maintain an accurate membership and attendance roster of all committees of the Medical Staff.

Active Medical Staff Members and Affiliated Professionals appointed to Medical Staff committees will have committee voting prerogatives. Individuals who are not Active Medical Staff Members or Affiliated Professionals will be appointed as non-voting committee members

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unless the Chair specifies voting prerogatives at the beginning of the Medical Staff year. Any such voting prerogatives will be documented in committee minutes at the beginning of the Medical Staff year and remain in effect for the committee membership appointment period of one (1) year.

Voting privileges, if issued by the Chair, will be for all matters before the committee during the course of the year.

11.2.6. Quorum

Unless otherwise stipulated in these Bylaws, a committee or subcommittee quorum consists of at least three (3) voting committee members present at the time of the discussion or vote. For the MEC, a quorum consists of at least ten (10) or more MEC members who are Members of the Active or Affiliated Medical Staff and are present at the time of the discussion or vote.

11.2.7. Manner of Action

Having established a voting quorum, the action of a simple majority of the voting committee members present will represent the action of the committee. Action may be taken without a meeting when, in the discretion of the Committee Chair, the action is sufficiently straightforward that discussion and deliberation is not necessary. In such an event, and if there are no objections from the voting committee members, action may be taken by vote through email or similar method and upon the approval of the number of voting committee members that constitutes a quorum.

11.2.8. Attendance Requirements

Excused absences can be issued by Chairs or Chiefs if requests for absences are submitted before the scheduled meeting. Any committee may invite the attendance of any individuals who may be useful to its work. All voting committee members are expected to attend or have a designee present for fifty percent (50%) of the committee's meetings.

11.2.9. Notice of Meetings

Chairs are responsible for scheduling meetings and providing adequate notice to committee members.

11.2.10. Minutes and Reporting

A. Minutes of all meetings, unless otherwise stated, will be forwarded to the Medical Staff Services Department, which will serve as the official repository for official business of the Medical Staff. Chairs of Committees will utilize a standardized meeting minutes template maintained by the Medical Staff Services Department. (See Appendix 4.)

B. Minutes of meetings will include, at a minimum, summaries and recommendations of any and all new policies or changes in policy. Such recommendations will be submitted to the Medical Executive Committee for its approval.

C. Each committee must submit reports to MEC on its activities, including policy recommendations, per the guidelines set forth below. Each report must be approved by the committee, to include subcommittees, before being brought forward to the MEC. Such reports will be made by the committee chair, or designee if not available:

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Bylaws	No less than every two years
Cancer	Twice yearly
Credentials	Every month
Critical Care	Twice yearly
Ethics	Twice yearly
Infection Control	Twice yearly
Well Being	Twice yearly
Operating Room	Twice yearly
Pharmacy and Therapeutics	Every month
Performance Improvement and Patient Safety	Every month
Utilization Management Committee	Twice yearly
Lab Committee	Every three months

D. Minutes of all meetings of standing committees, as well as any committee addressing peer review processes, are confidential as peer review processes under Section 1157 of the Evidence Code as is all material caused to be prepared for the use of said committees. Likewise, any business before these peer review bodies must be treated with the utmost confidentiality and not be discussed or disseminated outside of the protection of the peer review body or organization except as allowed or required by law.

11.2.11. Special Meetings

Special meeting of any standing committee may be called or requested by the Chair or Chief thereof, by the Chief of Staff, or by one-third (1/3) of the committee's voting members, but not less than two (2) voting members. The agenda must be included in the call to meeting. Notice must be given in writing at least two (2) weeks in advance of such called meeting to all voting members of the committee. Only matters included in the agenda may be considered at a special meeting.

11.2.12. Terms of Committee Members

Unless otherwise specified, committee members are appointed for term of one (1) year.

11.2.13. Removal

If a member of a committee ceases to be a Member in good standing of the Medical Staff or an Affiliated Professional in good standing or suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that committee member may be removed by the Chair and Chief of Staff. Any committee member whose employment or contract relationship with the Hospital or whose membership in the Medical or Affiliated Staff ends under any provision of these Bylaws is automatically removed from membership in each committee on which they had served.

11.2.14. Vacancies

Unless otherwise specifically provided, vacancies on any committee will be filled in the same manner in which an original appointment to such committee is made, provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Chair and Chief of Staff.

11.3. Medical Executive Committee (MEC)

11.3.1. Composition of MEC

The MEC consists of a group of voting members and group of non-voting members.

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Voting members the Officers of the Medical Staff, the Chiefs of the twenty (20) Clinical Services identified in subsection 9.1.2 herein, the Director of Health, the Chief Medical Officer of the San Francisco Health Network, the Chief Executive Officer, the Vice Dean, the Chair of the Credentials Committee, the Chief Medical Officer (CMO), the Chief of Performance Excellence, four (4) At-Large representatives (each either a Member or Affiliated Professional, with at least one Affiliated Professional) elected in accordance with these Bylaws, and up to three (3) representatives of the House Staff appointed by the Chief of Staff.

Non-voting members include the Chief Nursing Officer, an Affiliated Professional who co-chairs the Committee for Interdisciplinary Practice (CIDP), the Associate Chief Medical Officer (ACMO) of Medical Surgical Services, the ACMO of Perioperative Services, the ACMO of Critical Care Services, the ACMO of Care Coordination, the ACMO of Performance Excellence, the Medical Director of Performance Excellence and Improvement, the Chief Pharmacy Officer for the San Francisco Department of Public Health.

The Chief of Staff may invite other persons to attend meetings.

11.3.2. Attendance and Voting

A. It is the expectation that all Members and Affiliated Professionals on MEC will attend MEC meetings and will send an alternate when unable to attend. If a Member or Affiliated Professional fails to attend fifty percent (50%) of the MEC meetings during a Medical Staff Year, the Chief of Staff may appoint an alternate to serve in that Member or Affiliated Professional's place for the following Medical Staff Year.

B. Each At-Large representative has one (1) vote.

C. When a Chief of Service cannot attend a meeting, the Chief may designate an alternate to attend and exercise a proxy vote in the Chief's absence.

D. When a Chief of Service also holds the position of an officer of the Medical Staff or serves as the Vice Dean, no additional member of the MEC will be named, and that single individual will represent both membership categories and have only one (1) vote.

E. The three (3) representatives of the House Staff will collectively have a single vote.

11.3.3. Officers and At-Large Representatives

A. The current or acting Chief of Staff will serve as the Chair of the MEC.

B. The Chief of Staff-Elect will serve a one (1) year term when elected at the annual meeting of the Medical Staff or will serve for the remainder of the unexpired term of the vacancy the Chief of Staff-Elect fills when elected by the MEC.

C. The Chief of Staff-Past will serve a one (1) year term after completion of the Chief's year as Chief of Staff.

D. The four (4) At-Large MEC representatives who are elected will not serve more than three (3) consecutive one (1) year terms. However, an At-Large representative may not be appointed to a successive term if the At-Large representative has not attended at least fifty percent (50%) of the MEC meetings during the current appointment term.

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E. Vacancies in any of the four (4) At-Large representative positions arising during the Medical Staff Year will be filled by the nomination of a Member of the Active Medical Staff or Affiliated Professional by the Chief of Staff and approval by a vote of the MEC.

11.3.4. Duties of MEC

The Medical Staff delegates to the MEC broad authority to oversee the operations of the Medical Staff. Under the leadership of the Chief of Staff, and without limiting this broad delegation of authority, the MEC must perform in good faith the duties listed below.

F. Represent and act on behalf of the Medical and Affiliated Staff, subject to such limitations as may be imposed by these Bylaws;

G. Coordinate the activities of the Medical Staff committees and of the Clinical Services;

H. Receive and act upon reports and recommendations from Medical Staff Committees and Clinical Services;

I. Provide a forum in which the Medical Staff leadership can discuss issues and recommendations with the Chief Executive Officer, Chief Nursing Officer, Chief Financial Officer, Chief Medical Officer, and Vice Dean;

J. Fulfill the Medical and Affiliated Staff's accountability to the Governing Body for the quality of care rendered to patients;

K. Ensure that the Medical Staff and Affiliated Professionals are kept abreast of new laws, regulations, licensing and accreditation standards, and CMS Conditions of Participation;

L. Review the credentials of all Applicants and make recommendations to the Governing Body for Member and Affiliated Staff appointments, assignments to departments, and delineation of Clinical Privileges and Standardized Procedures;

M. Review the recommendations from the Credentials Committee and make recommendations to the Governing Body for reappointment and renewal or changes in Clinical Privileges, Affiliate Status and Standardized Procedures;

N. Ensure the professional and ethical conduct and competent clinical performance of Medical and Affiliated Staff Members, including the initiation of investigations and corrective action when warranted;

O. Review and approve all hospital-wide administrative and environment of care policies and clinical policies proposed by Medical Staff committees; and

P. Make recommendations directly to the Governing Body for its approval regarding the following:

1) The Medical Staff's structure;

2) The mechanism used to review credentials and to delineate individual clinical privileges,

3) Appointment and reappointment for Medical and Affiliated Staff Members;

4) Delineated Clinical Staff Privileges or Affiliated Status for each eligible individual;

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5) The mechanism for hearing procedures and the mechanism by which Membership on the Medical or Affiliated Staff may be terminated

6) The appropriate steps associated with restrictions on Clinical Staff Privileges or Affiliated Status ; and

7) The organization of the quality assessment and improvement activities of the Medical and Affiliated Staff.

Q. To amend these Bylaws and Rules and Regulations in accordance with Article 16, in the case of a documented need for an urgent amendment necessary to comply with law, regulation, or deficiency issued by The Joint Commission or state or federal regulating body; and

R. To take such other actions as may reasonably be deemed necessary in the best interest of the Medical Staff and Hospital. The authority delegated pursuant to this subsection 11.3.4 may be removed by amendment of these Bylaws and Rules and Regulations.

11.4. **Nominating Committee**

11.4.1. Composition

The Committee will be chaired by the Chief of Staff-Past or, in years in which there is no Chief of Staff-Past, the Chief of Staff. The Chair will appoint four (4) Members from the Active Medical Staff to serve on the committee, and at least one of these appointees will be from the Community Primary Care Service and at least one (1) will be an Affiliated Professional. The Vice Dean, Chief Medical Officer, and Chief Executive Officer will also be Members of the committee.

11.4.2. Duties

The committee will act upon the following requirements:

A. Nominate a Member of the Active Medical Staff to serve as Chief of Staff-Elect prior to the end of the first year of the Chief of Staff's term of office.

B. Should the incumbent Chief of Staff be re-nominated to serve an additional year, a previous Chief of Staff will also be nominated as Chief of Staff-Past until a new Chief of Staff-Elect is nominated.

C. Nominate four (4) Members of the Active Medical and Affiliated Staff to serve a one-year term as Members-At-Large on the MEC (including at least one(1) Affiliated Professional). Members-At-Large may not serve more than three (3) consecutive years. An At-Large Member may not be appointed to a successive term if that Member has not attended at least fifty percent (50%) of the MEC meetings during the current appointment term.

D. Election of the Medical Staff Officers will occur at the Annual Meeting in accordance with subsection 8.2.2 herein.

11.4.3. Meetings

The Committee will meet as needed to carry out these duties and will maintain records of its activities and meetings.

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11.5. Ambulatory Care Committee

11.5.1. Composition

This committee will consist of Medical Staff Members from the Clinical Services:

E. A minimum of one (1) Active Physician Member of the Medical Staff or Affiliated Professional from: Medicine, Medical Subspecialty, Family and Community Medicine, Community Primary Care (CPC), Pediatrics, Obstetrics-Gynecology, Surgical Service, and Emergency Medicine. Members of the Medical Staff from other Clinical Services may be on the committee as deemed appropriate by the Co-chairs and Chief of Staff. This may include, but is not limited to, representatives from Hospital Administration, Nursing, Information
Services, Laboratory Medicine, Pharmacy, Radiology, and Quality Management.

F. The committee will be co-chaired by an Active Member of the Medical Staff from Community Primary Care and the Associate Chief Medical Officer for Specialty Care and Diagnostics or the Associate Chief's designee.

11.5.2. Duties

The committee will:

A. Address cross-department operational issues, with a focus on communication, coordination of services, and inter-disciplinary problem solving. The committee will engage on-and off-campus primary care, medical and surgical specialty services, and diagnostic and ancillary services in identifying and addressing areas of need.

B. Serve as a forum to discuss issues related to the planning, development, quality, and delivery of integrated ambulatory care services.

C. Lead the development of Hospital policies, procedures, practices, and measurement tools that are common to department, services, and programs providing ambulatory care services.

D. Review clinic-specific practices as needed to ensure that they are aligned with the Hospital's mission and operational and organizational systems.

E. Identify opportunities to improve care in the ambulatory setting: that relate to clinical, diagnostic, or ancillary services; that relate to patient experience; or at the request of committee members or the Chief of Staff.

F. Develop and maintain a communication network for the Hospital and CPC leaders in ambulatory care.

G. Facilitate linkages and collaboration between: primary care in the sub-specialty care providers; hospital based and community based providers; and medical providers and other clinical disciplines.

11.5.3. Meetings

This Committee will meet at least quarterly but as frequently as necessary to carry out its duties and will maintain records of its proceedings and activities.

11.5.4. Reporting

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This Committee must submit a written report to the MEC on its activities, including policy recommendations, annually.

11.6. **Bylaws Committee**

11.6.1. Composition

This Committee will consist of at least seven (7) Members of the Active Medical Staff including the Chief of Staff, Chief of Staff-Elect, Chiefs of Staff-Past, the Chief Medical Officer, one representative from Hospital Administration, one representative from the Dean's Office, and one representative from the CPC service. The Chair will be the Chief of Staff-Elect or co-chaired with the Chief of Staff. While Affiliated Staff Members are not voting members, they may be invited to join the committee to give input to voting members.

11.6.2. Duties

The Committee will conduct a periodic review of the Medical Staff Bylaws and Rules and Regulations no less than every two years and submit recommendations for changes to the MEC prior to any required notification of the Active Medical and Affiliated Staff.

11.6.3. Meetings

The Committee will meet at least annually but as frequently as necessary to carry out its duties and will maintain records of its proceedings and activities.

11.7. **Cancer Committee**

11.7.1. Composition

The Cancer Committee will consist of five (5) Active Medical Staff Members representing each of Diagnostic Radiology, Pathology, Medical Oncology, Palliative Care, and General Surgery. Other Members will include: the Cancer Program Administrator, an Oncology Nurse, a Radiation Oncologist, a Social Worker, a Certified Tumor Registrar, a Performance Improvement representative, someone from Clinical Research, a Genetics professional/counselor, someone from Rehabilitation Services, a Registered Dietician, and a Pharmacist.

11.7.2. Duties

The Cancer Committee will:

A. Actively supervise the Tumor Registry doing quality review of abstracting, staging, and completeness of extent of disease information. This will include ensuring that the Tumor Registry meets the standards of the American College of Surgeons and Commission on Cancer.

B. Appoint and oversee the functions of the Tumor Board, a separate, multidisciplinary, weekly consultative and education committee.

C. Perform continuous quality improvement functions for the Medical Staff with respect to cancer patients. These include working with individual Clinical Services and Hospital Administration as well as performing patient care evaluations as mandated by the Commission on Cancer.

D. Ensure that consultative services from all major disciplines are available for all Hospital cancer patients.

E. Ensure that educational programs for the Medical and Affiliated Staff include all major cancer treatment sites.

11.7.3. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities.

11.7.4. Reporting

This Committee must submit a written report to the MEC on its activities, including policy recommendations, on a twice-yearly basis.

11.8. Credentials Committee

11.8.1. Composition

The Credentials Committee will consist of at least eight (8) Members of the Active Medical Staff, including the Chief of Staff, an officer of the MEC, one (1) Member from the CPC service, and at least one Affiliated Staff Member of the Interdisciplinary Practice Subcommittee. Two (2) of the Members will be Chiefs or Assistant Chiefs of Clinical Services and at least one Member will be from a clinical area where surgery is practiced (Surgery, Ob/Gyn., Orthopedics, Otolaryngology, or Neurosurgery).

11.8.2. Duties

The Credentials Committee will:

F. Review the credentials of Applicants and make recommendations for membership and Affiliate Status and delineation of Clinical Privileges and Standardized Procedures in compliance with these Bylaws;

G. Make a report to the MEC on each Applicant for Medical and Affiliated Staff membership, Clinical Privileges, and Affiliate Status which will include recommendations from the appropriate Chief of Service; and

H. Review all information available regarding the competence of Medical and Affiliated Staff Members, and as a result of such review makes recommendations for the granting of Clinical Privileges or Affiliate Status, reappointments, and the assignment of Applicants to the various Clinical Services as provided in theses Bylaws.

11.8.3. Meetings

The Credentials Committee will meet monthly at least ten (10) times per year and maintain a permanent record of its procedures and activities.

11.8.4. Reporting

The Credentials Committee must report to the MEC regarding approval of Medical and Affiliated Staff, which includes recommendations from the appropriate Chief of Service monthly.

11.8.5. Subcommittees

A. Clinical Interdisciplinary Practice Subcommittee (CIDP)

(1) Composition

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The Subcommittee will consist of the Chief Nursing Officer, the Chief Executive Officer or their designees, and an equal number of Physicians appointed by the MEC and registered nurses appointed by the Chief Nursing Officer. Affiliated Staff Members who are licensed or certified in professions other than nursing will also be included in the Subcommittee.

(2) Duties

This Subcommittee will:

Review and approve standardized procedures and privileges and protocols for patient care activities of the Affiliated Staff Members in accordance with the requirements of Title 22 of the California Code of Regulations governing committees on interdisciplinary practice.

(3) Meetings

This Subcommittee will meet at least quarterly and maintain permanent record of its proceedings and activities.

(4) Reporting

This Subcommittee must report and forward recommendations to the Credentials Committee on a monthly basis regarding approval as an Affiliated Staff Member.

11.9. Critical Care Committee

11.9.1. Composition

This Committee will consist of: Active Medical Staff Members who are Directors or Assistant Directors of critical care units and the Emergency Department; a nurse representative from each critical care unit and the Emergency Department; and one (1) representative each from Nursing Administration, Hospital Quality Management, Post Anesthesia Recovery, and Respiratory Therapy. One (1) House Staff Member will also be invited to serve.

11.9.2. Duties

This Committee will coordinate procedures, practices, and equipment in the various emergency areas in critical care units of the Hospital and will make recommendations to the MEC regarding these and related quality of care matters.

11.9.3. Meetings

This Committee will meet monthly at least ten (10) times a year and maintain permanent records of its proceedings and activities.

11.9.4. Reporting

This Committee must submit a report to the MEC on its activities, including policy recommendations, on a twice-yearly basis.

11.9.5. Subcommittees

A. Donor Council Subcommittee

(1) Composition

The Subcommittee will consist of at least one representative, who is a Medical Staff Member or Affiliated Professional from each of the following areas: Critical Care; Medical

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Staff; Attending Neurologist/Neurosurgeon; a nurse representative from each critical care unit; the Emergency Department; and the Medical-Surgical, Peri-Operative, and Perinatal divisions. The Subcommittee will also include a representative from the Hospital's Organ Procurement Organization (OPO). A physician will serve as Chair of this Subcommittee.

(2) Duties

The Subcommittee will:

- Review data collected by the OPO;
- Prepare reports on donor statistics for Quality Management and the Critical Care Committee;
- Review and revise Hospital policies, as needed;
- Review and discuss concerns related to the donor process; and
- Coordinate education activities hospital-wide, as needed.

(3) Meetings

The Subcommittee will meet quarterly and maintain permanent records of its proceedings and activities.

(4) Reporting

The subcommittee must report to the Critical Care Committee on a twice-yearly basis.

11.10. Ethics Committee

11.10.1. Composition

The Committee will consist of no fewer than fifteen (15) Members. These Members will include: representatives of the Medical and Nursing Staffs, the Critical Care Units, the inpatient and outpatient departments; representatives of Hospital Administration and the Quality Management Department; and a Deputy City Attorney. One (1) Member of the House Staff will also be invited to serve.

11.10.2. Duties

This Committee will educate the Hospital community regarding ethical principles, facilitate interchange in ethical decisions, and help develop ethical guidelines. The Committee, or a subgroup of the Committee, will also meet as needed to provide consults on specific situations or issues.

11.10.3. Meetings

The Ethics Committee will meet monthly at least ten (10) times a year and maintain a permanent record of its proceedings and activities.

11.10.4. Reporting

The Ethics Committee must submit a written report to the MEC including policy recommendations, on a twice-yearly basis.

11.11. Infection Control Committee

11.11.1. Composition

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This Committee will consist of Members from the Active Medical Staff diverse services involved in clinical care and operations. Current members include:

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A. Medical Staff:
   1. Laboratory Medicine
   2. Medicine, with expertise in Infectious Disease
   3. Medicine, with expertise in Occupational Health (when position is filled)
   4. Pediatrics
   5. Anesthesiology
B. Infection Prevention and Control Program Manager
C. Chief Quality Officer
D. Inpatient Nursing Administrative Representative
E. 4A SNF Nurse Manager
F. Outpatient Nursing Director
G. Patient Safety Officer
H. Senior Industrial Hygienist
I. Infection Control Department Members, including Infection Control Practitioners, Analyst, and Data Manager
J. Infectious Diseases Pharmacist
K. Environmental Services
L. Facilities Management
M. Occupational Health
N. Additional Ad Hoc or Consultant Members (non-voting):
   1. Sterile Processing Department Manager;
   2. Operating Room Manager; and
   3. Food & Nutritional Services Director.

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11.11.2. Duties

This Committee is responsible for directing the infection control program for the Hospital and other entities covered under the Hospital license, such as on-site clinics and the 4A Skilled Nursing Facility. The Committee will: guide and help prioritize the activities of the Infection Control staff; assist with definitions and guidelines for surveillance of infections; receive reports of infection rates, clusters of infections, and outbreaks; promote a prevention program designed to minimize infection hazards; review procedures and programs for surveillance and prevention of infections in healthcare workers and other staff; and review and approve infection control policies and procedures. The Infection Control Committee may institute appropriate control measures or investigations when there is a reasonable concern of danger to patients or staff.

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11.11.3. Meetings

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This Committee will meet at least bimonthly and maintain a record of proceedings and activities.

11.11.4. Reporting

The Infection Control Committee must submit a written report to the MEC on its activities, including policy recommendations, semi-annually.

11.12. Well Being Committee

11.12.1. Composition

The Well Being Committee is comprised of no less than three (3) Active Members of the Medical and Affiliated Staff, a majority of which, including the Chair, will be physicians. Insofar as possible, members of this Committee should not serve as active participants of other peer review or continuous quality improvement committees.

11.12.2. Duties

The duties of the committee are as follows:

O. To foster and actively support the well-being of Medical Staff Members and, as appropriate and consistent with labor agreements, if applicable, Affiliated Professionals;

P. To support Chiefs of Service in addressing well-being issues among Medical Staff Members and Affiliated Professionals on their team, including faculty, staff, and trainees;

Q. To provide education to Medical and Affiliated Staff Members about illness and impairment issues specific to such Members ;

R. To facilitate self-referral by Medical Staff Members and, as appropriate, Affiliated Professionals and referral by other organization staff;

S. To facilitate referral of the affected Medical Staff Members and, as appropriate, Affiliated Professionals to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;

T. To provide for the maintenance of the confidentiality of the Medical Staff Members and Affiliated Professionals, as appropriate and consistent with existing human resources practices and labor memorandums of understanding, seeking referral or referred for assistance, except: as limited by law or ethical obligation; as allowed by these Bylaws or any labor agreement; or when the safety of a patient is threatened;

U. To assure evaluation of the credibility of a complaint, allegation, or concern;

V. To monitor the affected Medical Staff Member or Affiliated Professional and the safety of patients until the rehabilitation or any disciplinary process is completed;

W. To assure a reporting to the Medical Staff leadership in instances in which a Medical Staff Member or Affiliated Professional is providing unsafe treatment; and

X. To provide assistance, counseling, and referrals for disruptive Medical Staff Members or Affiliated Professionals

11.12.3. Meetings

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The Committee will meet at least every 3 months, and more frequently as necessary. It will maintain only such record of its proceedings and activities as it deems advisable.

11.12.4. Reporting

The Well Being Committee must submit a written report to MEC on its activities, including policy recommendations, semi-annually.

11.13. Operating Room Committee

11.13.1. Composition

This Committee will consist of:

- Medical Staff Members representing all services performing procedures within the perioperative areas;
- The Department of Anesthesia;
- The Perioperative Nursing Director;
- The Chief of the Infection Control Committee;
- The Director of the Blood Bank;
- A representative from Hospital Administration; and
- One (1) non-voting Member of the House Staff (who will be invited to serve).

11.13.2. Duties

The Operating Room Committee is responsible for the evolution of the safe, proper, and efficient utilization of Operating & Procedural Rooms within the Hospital, including the Surgical and Procedural unit and the operating rooms in Labor & Delivery. This Committee is responsible for the development of policies and procedures regarding the safe, proper, and efficient conduct of surgical procedures.

11.13.3. Meetings

This Committee will meet monthly at least ten (10) times a year and maintain permanent records of its proceedings and activities.

11.13.4. Reporting

The Operating Room Committee must submit a written report to MEC on its activities, including policy recommendations, on a twice-yearly basis.

11.14. Pharmacy and Therapeutics Committee

11.14.1. Composition

This Committee will consist of at least five (5) Members of the Active Medical Staff including one (1) representative from the Community Primary Care service. In addition, representatives from the Pharmaceutical Service, the Nursing Service, Nutrition Services, Hospital Administration, Affiliated Professionals and other services as appropriate will serve with a vote. The Director of Pharmaceutical Services, or designee, will serve as Secretary to the Committee. A Member of the Medical Staff with expertise in pharmacology shall serve as Chair. The Chief Pharmacy Officer will serve as Vice Chair.

11.14.2. Duties

This Committee is responsible for the development and surveillance of all drug use policies and practices within the Hospital and its clinics. The Committee will assist in the formation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to pharmaceuticals in this Hospital and its clinics. It will also perform the following specific functions:

A. Serve as an advisory group to the Medical Staff and the Department of Pharmaceutical Services on matters pertaining to the choice of available drugs;

B. Publish and maintain the Hospital formulary;

C. Establish and maintain standards concerning the use and control of investigational drugs and of research in the use of approved drugs;

D. Make recommendations concerning drugs to be stocked on nursing units and other special services;

E. Prevent unnecessary duplication in stocking pharmaceuticals;

F. Evaluate clinical data concerning new pharmaceuticals requested for use in this Hospital and make recommendations to the MEC regarding what pharmaceuticals should be made available and placed on the formulary;

G. Review and recommend changes to medication use policies, guidelines, and standardized medication orders to ensure safe and appropriate prescribing, administration, and monitoring of medications;

H. Review and recommend changes in the electronic health record platform (*e.g.*, Epic) to improve the quality, safety, and efficiency of care delivered;

I. Review medication-related issues and content from groups including but not limited to the Clinical Decision Support Committee and the Procedural Sedation Subcommittee, and examples include review of ordersets, best practice advisories, smartsets, medication alerts, and guidelines for use;

J. Promote medication use safety; and

K. Report issues to the Performance Improvement and Patient Safety Committee.

11.14.3. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities.

11.14.4. Reports

This Committee shall submit a written report to MEC on its activities, including policy recommendations to the MEC monthly.

11.14.5. Subcommittees

The Committee will conduct the majority of its business through five (5) subcommittees. The Chair of each subcommittee will be a member of the Pharmacy and Therapeutics Committee and will be appointed by the Chair of the Committee with the approval of the Chief of Staff.

A. Antibiotic Advisory Subcommittee

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This Subcommittee is responsible for reviewing antibiotics and related therapies. The Subcommittee will assist the Formulary Review Subcommittee in conducting drug use evaluations for antibiotic therapy. The subcommittee will work closely with the Infection Control Committee and the Clinical Laboratories.

B. Formulary Review Subcommittee

This Subcommittee is responsible for evaluating all requests for changes to the Formulary including additions of new drugs, new uses for current drugs, and deletions from the Formulary. The Subcommittee will also conduct periodic reviews of drug classes to assess appropriate use and promulgate guidelines for the use of drugs in clinical areas as appropriate.

C. Nutrition Subcommittee

The Subcommittee will recommend therapeutic enteral and parenteral nutritional formulations for the Formulary and monitor and assess nutritional therapies. Additionally, the Subcommittee will review and approve policies and procedures relating to nutritional therapy of the Food and Nutritional Service, Outpatient Nutrition Service, and the Nutritional Support Services, including the Diet Manual.

D. Pain Management Subcommittee

This Subcommittee will recommend and periodically review a program to promote effective pain management. It will collaborate with the Medication Error Reduction Plan Subcommittee around policies related to pharmacotherapy of pain. It will review and recommend policies and procedures pertinent to pain management.

E. Medication Error Reduction Plan Subcommittee

This Subcommittee will set system-wide and department-specific policies to reduce medication errors and adverse drug events. The subcommittee will review and revise the California Department of Public Health-mandated Medication Error Reduction Plan annually to assess effectiveness and identify weaknesses or deficiencies that could contribute to errors. The subcommittee will also review and report all unusual occurrences related to medications and make recommendations to the Pharmacy and Therapeutics Committee on ways to prevent such occurrences in the future.

11.14.6. Subcommittee Reporting

The subcommittees will report to the Pharmacy and Therapeutics Committee monthly.

11.15. Performance Improvement and Patient Safety Committee (PIPS)

This is a Joint Hospital Administration and Medical Staff committee responsible for implementing the objectives of the organization-wide performance improvement and patient safety program. The committee takes an interdisciplinary and proactive approach to the prevention of adverse events, medical errors, and near misses, and promotes patient outcomes/safety and reduction of health disparities as the core values in providing quality patient care.

11.15.1. Composition

This Committee will consist of at least seven (7) physician representatives from the Active Medical Staff. Up to three (3) additional representatives from clinical services may

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include Affiliated Professionals. It will also include one (1) representative from each of Radiology, Clinical Lab, Pharmacy, Infection Prevention and Control, and Nursing. In addition, the Executive Leadership Team including the Chief Executive Officer, Chief Operations Officer, Chief Nursing Officer, Chief Pharmacy Officer, and UCSF Vice Dean will serve with one vote. The Administrative Director of Utilization Management and the Patient Safety Officer will also be Members. The Chief Executive Officer, Chief Medical Officer, or an Associate Chief Medical Officer will serve as the Chair, and the Chief Quality Officer will serve as Vice-Chair.

11.15.2. Duties

This Committee:

A. On an annual basis, reviews the effectiveness of Hospital Performance Improvement and Patient Safety Program in meeting the organizational-wide purpose, goals, and objectives and revises the program as necessary.

B. Identifies organization-wide trends, patterns, and opportunities to improve aspects of patient care and safety through the review and analysis of data obtained from focused reviews and sentinel events in the Joint Commission Sentinel Event Alerts, patient case reviews, risk management reports, hospital claims, patient and staff surveys, utilization review data, patient/visitor concerns, clinical service and ancillary/diagnostic department performance improvement reports, ongoing medical record review, and other sources as appropriate.

C. Formulates and recommends actions for improving patient care and safety to clinical services, ancillary/diagnostic departments, and performance improvement committees as appropriate.

D. Makes recommendations based on an evaluation of the care provided (e.g., efficacy, appropriateness) and how well it is done (e.g., availability, timelines, effectiveness, continuity with other services, safety, efficiency, respect, and caring).

E. Submits an annual report to the MEC.

F. Facilitates a multidisciplinary, interdepartmental collaborative approach to improving the quality of patient care and safety, and appropriate utilization of resources through the designation of Performance Improvement.

11.15.3. Meetings

The Committee will meet monthly at least ten (10) times a year. The Committee will maintain permanent records of its proceedings and activities.

11.15.4. Reporting

The Performance Improvement and Patient Safety Committee must report and forward recommendations monthly to the Joint Conference Committee through the Chief Medical Officer and Chief Quality Officer, based on the review and recommendations made by the MEC.

11.15.5. Subcommittees

The Committee will maintain and utilize the following subcommittees to do the work as described:

A. Code Blue Subcommittee

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(1) Composition

This subcommittee will consist of physician representatives from Cardiology, Emergency Department, Pulmonary Service, and Anesthesia. Additional representatives from Respiratory, Nursing Pharmacy, Product Evaluation and Quality Management will also serve.

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(2) Duties

This subcommittee will oversee the organization of the Code Blue Team (*e.g.*, personnel composition, Member's roles and responsibilities, availability of equipment, scope of service area, and communication mechanisms). All findings from codes related to quality improvement activities will be reported to this subcommittee for evaluation and recommendations.

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(3) Meetings

The Code Blue Subcommittee will meet monthly and maintain permanent records of its proceedings and activities.

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(4) Reporting

The Code Blue Subcommittee must submit a written report to PIPS on a once-yearly basis.

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B. Event Analysis & System Improvement Subcommittee (EASI)

(1) Composition

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This subcommittee will consist of at least eight (8) Members of the Active Medical Staff, including representatives from the Clinical Services of Medicine, Surgery, Pediatrics, Family and Community Medicine, Obstetrics and Gynecology, Psychiatry, and Emergency Medicine. In addition, representatives from Hospital Risk Management, UCSF Risk Management, Hospital Administration, Quality Management, and the Chief Nursing Officer or designee will also serve. The Medical Director of Risk Management or designee will serve as Chair for this subcommittee. The Director of Risk Management will serve as Vice Chair.

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(2) Duties

The Subcommittee will:

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a. Provide oversight of the quality and safety event review process;

b. Provide oversight to ensure identification of clinical risk, system vulnerabilities, and opportunities for quality improvement;

c. Ensure implementation of recommend corrective action to mitigate or eliminate future recurrence of similar events; and

d. Establish a framework that improves clinical and operational systems, patient safety, and quality outcomes using a shared accountability model.

(3) Meetings

The subcommittee will meet monthly at least ten (10) times per year and maintain permanent records of its proceedings and activities.

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(4) Reporting

The Subcommittee must submit a written report to PIPS on a twice-yearly basis.

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C. Transfusion Subcommittee

(1) Composition

This subcommittee will consist of the Nurse Manager for the Operating Room, the Nurse Manager for the Surgical Clinics, the Blood Bank Senior Supervising Technologist, the Director of the Transfusion Service/Division Chief of the Blood Bank, and one (1) Member each from the Departments of Anesthesia, Surgery, Obstetrics, Pediatrics/Neonatology, Hematology/Oncology, and Emergency Services.

(2) Duties

This subcommittee will review transfusion-related issues in the Hospital, including the appropriateness of the use of blood and blood components, blood component wastage, and all transfusion reactions. The findings of such reviews will be reported to the PIPS Committee and Chiefs of the Clinical Services, when appropriate. The subcommittee will develop and approve policies and procedures regarding transfusion practices and make recommendations based on results.

(3) Reporting

This subcommittee must submit a written report to PIPS on a twice-yearly basis.

D. Trauma Program Operational Process Performance Subcommittee

(1) Composition

This subcommittee will be chaired by the Trauma Medical Director, and the Trauma Program Manager will serve as Vice Chair. The subcommittee will consist of the representatives from the Departments of Emergency Medicine, Anesthesia, Neurosurgery, Orthopedics, Radiology, Physical Medicine, Rehabilitation, Respiratory Therapy, Perioperative Services, Laboratory Medicine, and Pediatrics; the Nursing Directors or Managers of the Surgical ICU, Emergency Department, Surgical Nursing, PACU, and Operating Room; Neurosurgical, Emergency Department, and Surgical CNS representatives; Risk Management and Quality Management Nursing representatives; Trauma PI Coordinators, Trauma, Orthopedic, and Neurosurgical NP representatives; the Medical Director of SFFD Emergency Medical Services Division, ZSFG Base Hospital Coordinator, EMSA Medical Director and Trauma Coordinator, and San Mateo EMS Clinical Coordinator; and other professionals who are invited to participate as needed.

(2) Duties

This subcommittee will address, assess, and correct global trauma program and system issues. The membership will review all major clinical activities and systems of trauma care and will:

a. Evaluate system and medical performance through objective and systematic monitoring;

b. Identify, analyze, and track problems;

c. Develop and implement plans for improvement, resolution, and modification of current systems of trauma care;

d. Communicate the results of reviews and plans of correction to all program related services/departments;

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e. Trend and measure the effectiveness of corrective action; and

f. Document the reporting of patient safety initiatives and continuous quality improvement activities.

(3) Meetings

This subcommittee will meet on a monthly basis at least ten (10) times per year and maintain permanent records of its proceedings and activities.

(4) Reporting

The Chair and Co-Chair of the Trauma Program Operational Process Performance and Trauma Multidisciplinary Peer Review Subcommittees will submit a written combined Trauma report to PIPS on a twice-yearly basis.

E. Trauma Multidisciplinary Peer Review Subcommittee

(1) Composition

This subcommittee will be chaired by the Trauma Medical Director. The subcommittee will consist of the Chiefs-of-Service, or their designated representatives, of the following Departments: Surgery, Emergency Medicine, Anesthesia, Neurosurgery, Orthopedic Surgery, Radiology, Laboratory Medicine/Blood Bank, and Pediatrics. Additional members include the Co-Directors of Surgical ICU, the Hospital Director of Patient Safety and Performance Improvement, and all members of the Department of Surgery regularly participating in the care of acutely injured patients. Other attendees will include the Trauma Program Manager and Trauma Performance Improvement staff.

(2) Duties

This subcommittee will assure the equality and appropriateness of trauma care at this Hospital as it relates to performance of individual providers and the interaction between providers of different disciplines. The subcommittee will review clinical activity and outcomes (deaths, complications, errors) and will:

a. Evaluate provider performance through objective and systematic monitoring;

b. Analyze problems related to provider performance and develop plans for improvement, resolution, and modification of current practices;

c. Communicate the results of review and plans of correction to all members of the Committee and the Trauma Panel;

d. Facilitate and direct a development of clinical management guidelines or protocols for the management trauma; and

e. Measure the effectiveness of any corrective action taken or protocols generated.

(3) Meetings

The subcommittee will meet on a monthly basis at least ten (10) times/year and maintain permanent records of its proceedings and activities.

(4) Reporting

The Chair and Co-Chair of the Trauma Program Operational Process Performance and Trauma Multidisciplinary Peer Review Subcommittees will submit a written combined Trauma report to PIPS on a twice-yearly basis.

F. Tissue Subcommittee

(1) Composition

This subcommittee will consist of attending physicians from Pathology (including the Chief of Pathology) selected by the Tissue Subcommittee Chair, and other members that the Chief of Staff appoints from surgical subspecialties and other areas.

(2) Duties

a. The Tissue Subcommittee is responsible for the review of selected surgical case reports; those with pathology reports will correlate pre and post-operative diagnosis and pathology findings. Discrepancies will be presented to the Performance Improvement and Patient Safety Committee. The Tissue Subcommittee will review tissue specimens submitted to Pathology to ensure proper tissue handling and adequate completion of requisition forms.

b. The subcommittee will also make recommendations based on results.

(3) Meetings

The Tissue Subcommittee will meet as needed, but no less than twice per year, and maintain permanent records of its proceedings and activities.

(4) Reporting

The Tissue Subcommittee must submit a written report to PIPS quarterly.

G. Procedural Sedation Subcommittee

This subcommittee will oversee the administration of moderate or deep sedation and anesthesia. The activities of the subcommittee will include physician and registered nursing training and formulating policy and procedures for the administration of moderate or deep sedation and anesthesia by non-anesthesia trained personnel.

(1) Composition

The subcommittee will be Co-Chaired by the Chief of Anesthesia or designee and a nursing administrator and consist of physician and nursing representatives from all clinical services providing procedural sedation, including: Gastroenterology, Radiology, Oral and Maxillofacial Surgery, Pulmonology, Emergency Medicine, Critical Care, Women's Option Clinic, Neonatal Intensive Care Unit, Post Anesthesia Care Unit, the Cardiac catheterization lab, and the Clinical and Translational Science Institute.

(2) Duties

This subcommittee is tasked with setting systemwide and department-specific procedural sedation policy to ensure the safe delivery of procedural sedation and to meet regulatory compliance requirements for procedural sedation throughout the institution. Policies will be reviewed and revised no less frequently than every three years. The subcommittee will track audit data on a quarterly basis. All procedural sedation-related unusual occurrences will be discussed and any recommendations forwarded to the involved department.

(3) Meetings

The subcommittee will meet monthly at least ten (10) times annually and maintain permanent records of its meetings and activities.

(4) Reporting

The subcommittee must submit a written report to PIPS on a twice-yearly basis.

11.16. Utilization Management Committee

11.16.1. Composition

This Committee will consist of at least three (3) Members of the Active Medical Staff or Affiliated Professionals, including the Associate Chief Medical Officer of Care Coordination (or their designee), who will serve as the Chair of the committee. The Committee must include at least two doctors of medicine or osteopathy. The committee will include representation from Ambulatory Care and Behavioral Health Services. Other individuals from the clinical, administrative, and support services whose participation is deemed necessary to increase the effectiveness of the work of the committee will be invited to meetings as needed.

11.16.2. Duties

This Committee has two primary functions:

A. Provide oversight for all Utilization Management functions, and

B. Make rational and system-coordinated recommendations on the priority of clinical services and resource allocation related to clinical care based on best available evidence.

11.16.3. Utilization Data Review

The Committee will review data related to Utilization Management at least semi-annually, including, but not limited to:

- Medical necessity/appropriateness of hospital admissions and readmissions
- Medical necessity/appropriateness of continued stay and treatment authorizations
- Lengths of stay variations and timeliness of discharge
- Professional services furnished, including drugs and biologicals
- Appropriate availability and use of ancillary services
- Overuse, underuse, and timeliness in provision of services
- Therapeutic procedures
- Adequacy of medical record documentation
- Third party payer denials
- Utilization of the Tertiary Care Contract
- Contracted Health Plan utilization and cost data
- Out-of-network referral costs
- Utilization Review Plan (review and approve annually)

Review of the above data elements may be concurrent or retrospective, and may be conducted on a sample basis for cases reasonably assumed to be outliers based on lengths of stay or extraordinary high costs. The Utilization Management Committee will work closely with financial services, social services, case management, patient placement services, and the Medical

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Staff to maximize appropriate utilization of resources. The Utilization Management Committee will report relevant findings to the Medical Executive Committee including problems, areas of opportunity, and actions addressed with departments, Clinical Services, Medical Staff, and other hospital entities.

11.16.4. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities. The Utilization Management Committee will work closely with relevant stakeholders (including but not limited to Patient Financial Services, Behavioral Health Services, Ambulatory Care Services, and the Medical Staff) to maximize appropriate utilization of resources. One meeting per year must be dedicated to review of the Utilization Review Plan.

11.16.5. Reporting

This Committee must submit a written report on its activities to the MEC, including policy recommendations, semi-annually.

11.17. Laboratory Utilization Committee

11.17.1. Composition

This Committee will consist of at least five (5) Members of the Active Medical Staff including one (1) representative from the CPC service. The laboratory medicine resident will be invited and encouraged to participate. In addition, representatives from the Hospital Administration as well as nursing, pathology, Infectious Diseases, and Primary Care services, Specialty Care Services, and other services as appropriate will serve with a vote. The Director of Clinical Laboratory Services, or designee, will serve as Chair of the Committee.

11.17.2. Duties

This Committee is responsible for the development and surveillance of all laboratory testing policies and practices within the Hospital and its clinics. The Committee will assist in the formation of broad professional policies regarding the selection and availability of clinical laboratory tests, their reporting structure, and the communication of newly available tests to the clinical staff. The Committee will also perform the following specific functions:

A. Serve as an advisory group to the Medical Staff and the Department of Clinical Laboratory Services on matters pertaining to the choice of available laboratory testing;

B. Evaluate clinical data concerning new clinical lab tests requested for use in this Hospital and make recommendations to the Medical Executive Committee regarding what lab tests should be made available for order in the EHR;

C. Advise clinical staff in the appropriate analysis and follow-up for specific laboratory tests;

D. Advise in relation to and determine designation status for critical lab values and modify protocols for notification of critical results;

E. Manage the approval process and utilization of laboratory tests sent to outside reference labs; and

F. Report issues to the PIPS Committee as needed.

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11.17.3. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities.

11.17.4. Reports

This Committee must submit a written report to MEC on its activities, including policy recommendations, quarterly.

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ARTICLE 12. MEETINGS OF THE ENTIRE MEDICAL STAFF

12.1. Annual Meeting

An annual Medical Staff meeting will be held within sixty (60) days of the end of the Medical Staff year.

Each Member of the Active Medical Staff is expected to attend the annual meeting of the Medical Staff at least once every two years and special Medical Staff Meetings duly convened pursuant to these Bylaws.

The agenda at the annual Medical Staff meeting will be:

A. Call to order

A. Approval of minutes of previous annual or special meetings of the Medical Staff

B. Annual Reports

1) Director of Health

2) Chief Executive Officer

3) Dean, School of Medicine

4) Vice Dean

5) Chief of Staff

C. Old Business

D. New Business

E. Adjournment

12.2. Special Meetings

A. The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff must call a special meeting within ten (10) days after receipt of a written request for same signed by not less than ten percent (10%) of the Active Medical Staff and stating the purpose for such meeting. The Chief of Staff will designate the time and place of any special meeting.

B. A written or printed notice stating place, day, and hour of any special meeting of the Medical Staff must be delivered, whether personally, by electronic mail or by mail, to each Active Member not less than seven (7) days before the date of such meeting. If mailed, the notice of the meeting is deemed delivered when deposited, postage prepaid, in a United States mail addressed to each staff Member at the address appearing on the records of the Hospital. The attendance of a Member at a meeting constitutes a waiver of notice of such meeting. No business may be transacted at any special meeting except that stated in the notice calling the meeting.

C. Twenty percent **(20%)** of the Active Medical Staff constitutes a quorum for special meetings.

D. The agenda will include reading of the notice of the meeting, transaction of business for which the meeting was called, and adjournment.

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12.3 Voting

A simple majority of the Active Members attending either the Annual meeting or a Special meeting will determine the outcome of the vote.

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ARTICLE 13. CONFIDENTIALITY OF INFORMATION; IMMUNITY AND RELEASES

13.1. Authorization and Conditions

By applying to be a Member, Affiliated Professional, or other role with the Medical Staff, as well as by applying for or exercising clinical privileges and/or standardized procedures with the Hospital, an Applicant:

A. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the Applicant's professional ability and qualifications;

B. Authorizes persons and organizations to provide information concerning such Applicant to the Medical Staff;

C. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under subsection 13.2.4 below; and

D. Acknowledges that the provisions of this Article are express conditions to any application described in this Section 13.1.

13.2. Confidentiality of Information

13.2.1. General

Discussions, deliberations, records, and proceedings of all Medical Staff committees having responsibility of evaluation and improvement of quality of care rendered in this Hospital will, to the fullest extent permitted by law, be confidential. This confidentiality protection includes, but is not limited to, information regarding any Member, Applicant, or Affiliated Professional, meetings of the Medical Staff, meetings of Clinical Services, meetings of committees of the Medical Staff, and meetings of ad hoc committees created by the MEC.

13.2.2. When Disclosure is Permitted

A. Dissemination or disclosure of discussions, deliberations, records, and proceedings may only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the MEC. Actions taken to address systems issues, information about corrective actions, conclusions, referrals for other investigations, and other high-level information may be shared if authorized by the Chief of Staff in consultation with the Vice-Dean, Chief Executive Officer, and/or City Attorney's Office.

B. In all other cases, access to such information and records is limited to authorized Members or Affiliated Professionals for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentially be maintained.

C. Information which is disclosed to the Governing Body or its appointed representatives in order that the Governing Body may discharge its lawful obligations and responsibilities will be maintained by that body as confidential.

D. Information contained in the credentials file of any Member or Affiliated Professional may be disclosed consistent with other provisions of these Bylaws, as required by law, or

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with the Member's or Affiliated Professional's consent to other medical staffs, hospitals, professional licensing boards, or medical schools.

E. Initiation of a corrective action investigation, submission of a report pursuant to Section 805 of the Business and Professions Code to the Member's or Affiliated Professional's professional licensing organization (such as the Medical Board), and adverse actions related to medical staff membership, privileges, and/or standardizes procedures will be reported to the peer review bodies of any other component of the San Francisco Health Network in which the Member or Affiliated Professional provides patient care services.

13.2.3. Breach of Confidentiality

Effective quality of care activities, peer review, and consideration of the qualifications of Members, Affiliated Professionals, and Applicants to perform specific procedures must be based on free and candid discussions within a quality improvement process. Any breach of confidentiality of the discussions, deliberations, records, or proceedings of Medical Staff Clinical Services or committees is outside appropriate standards of conduct for Members or Affiliated Professionals, violates these Medical Staff Bylaws, and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the MEC may undertake such corrective action as it deems appropriate. In particular, and without limitation, a breach of confidentiality includes any unauthorized voluntary testimony or unauthorized offer to testify before a court of law or in any other proceeding as to matters protected by this confidentiality provision.

13.2.4. Immunity from Liability

A. For Action Taken by the Medical Staff and Hospital.
Each representative of the Medical Staff and Hospital is immune, to the fullest extent provided by law, from liability to an Applicant, Member, or Affiliated Professional for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.

B. For Providing Information.
Each representative of the Medical Staff and Hospital and all third parties is immune, to the fullest extent provided by law, from liability to an Applicant, Member, or Affiliated Professional for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an Applicant to or Member or Affiliated Professional of the staff or who did, or does, exercise clinical privileges or provide services at this Hospital.

13.2.5. Activities and Information Covered

The confidentiality and immunity provided by this Article applies to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

A. Application for appointment, reappointment, clinical privileges, or standardized procedures;

B. Corrective action;

C. Hearings and appellate reviews;

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D. Utilization and quality assurance reviews;

E. Activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

F. Queries and reports concerning the National Practitioner Data Bank, peer review body or organization, or a professional licensing organization (such as the Medical Board of California), and similar queries and reports.

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ARTICLE 14. CONFLICTS AND DISPUTE RESOLUTION

14.1. Conflicts and Disputes between the Medical Staff and the MEC

A. The Chief of Staff must convene a meeting to resolve a conflict or dispute between the MEC and the Medical Staff upon receipt of a written petition, signed by at least twenty percent (20%) of the Active Medical Staff Members, that sets forth the rule, policy, or other significant matter at issue.

B. The meeting will include up to five representatives of the Active Medical Staff selected by the petitioners and an equal number of MEC Members selected by the Chief of Staff. The meeting will be chaired by the Chief of Staff, who will not be considered as one of the MEC representatives and who will not have voting privileges at this meeting.

C. The representatives of the Medical Staff and of the MEC will exchange information relevant to the conflict and work in good faith to resolve differences in a manner that respects the position of the Medical Staff, the leadership responsibilities of the MEC, and the safety and quality of patient care at the Hospital.

D. Resolution at this level requires a majority vote of the representatives of the Medical Staff and a majority vote of the representatives of the MEC.

E. Unresolved matters will be submitted to the Governing Body for final resolution.

14.2. Conflicts and Disputes between the Medical Staff and the Governing Body

A. The Chief of Staff must convene a meeting to resolve a conflict or dispute between the Medical Staff and the Governing Body upon a majority vote of the MEC or petition of at least twenty percent (20%) of the Active Members. The Chief of Staff will work with the Secretary of the Governing Body to ensure compliance with public notice requirements.

B. The Medical Staff will be represented by two officers of the Medical Staff and three Active Medical Staff Members selected by the Chief of Staff. The Governing Body will be represented by the Governing Body members on the Joint Conference Committee. The Hospital Chief Executive Officer and Vice-Dean will also be invited to attend this meeting and will not have voting privileges at this meeting.

C. The meeting will be chaired by the Chair of the Joint Conference Committee.

D. The meeting participants will gather and share relevant information and work in good faith to resolve differences in a manner that respects the position of the Medical Staff, the governing responsibilities of the Governing Body, and the safety and quality of patient care at the Hospital.

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E. Resolution at this level requires a majority vote of each of the following groups: (a) the representatives of the Medical Staff; and (b) the representatives of the Governing Body. Any such proposed resolution must be approved by a majority of the full Governing Body.

F. Unresolved matters must be submitted to the Governing Body for final resolution. The Governing Body will make its final determination giving consideration to the actions and recommendations of the Medical Staff, must not be arbitrary and capricious, and must act in keeping with its legal responsibilities to act to protect the safety and quality of patient care and to ensure the responsible governance of the Hospital.

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ARTICLE 15. RULES AND REGULATIONS

15.1. Rules and Regulations of the Medical Staff

The Medical Staff will be governed by such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These will relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Member. Agreement to abide by the Bylaws includes agreement to abide by the Rules and Regulations. The Rules and Regulations are incorporated into these Bylaws as if set forth herein. In keeping with The Joint Commission guidelines, ammendments to the Rules and Regulations are delegated to the Medical Executive Committee (MEC).

15.2. Rules and Regulations of the Clinical Services

Each Clinical Service must formulate its own rules and regulations and proctoring protocol for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations must be consistent with these Bylaws. Substantive changes must be reflected in the biennial clinical services report to the Medical Executive Committee and approved by the MEC and the Governing Body.

ARTICLE 16. ADOPTION AND AMENDMENT

16.1. Medical Staff Responsibility

16.1.1. Initial Responsibility

The Medical Staff has the initial responsibility and authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments thereto, which will be effective when approved by the Governing Body. Such approval must not be unreasonably withheld. This responsibility will be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing quality and efficient patient care and maintaining a harmony of purpose and effort with the Governing Body. Neither the Governing Body nor the Medical Staff may unilaterally amend the Medical Staff Bylaws.

16.1.2. Hospital Chief Executive Officer

The Hospital Chief Executive Officer must be consulted as to the impact of any proposed Bylaws amendments on Hospital operations and as to the feasibility of proposed amendments. The Hospital Chief Executive Officer may also develop and recommend Bylaws amendments to the Bylaws Committee or MEC for consideration.

16.1.3. Proposed Amendments

Proposed amendments will be reviewed and considered at a meeting of the Joint Conference Committee prior to distribution to the Medical Staff for a vote. The Governing Body Members of the Joint Conference Committee have the right to have their comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

16.2. Amendments

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The City Attorney's Office serves as counsel for the Medical Staff in relation to any amendments and will provide input on suggested amendments to these Bylaws.

The MEC will vote on the proposed amendments and upon an affirmative vote of a majority of a quorum must submit the amendments to the Active Medical Staff for approval or disapproval as set forth in Section 16.3 herein.

Upon a petition signed by at least twenty percent (20%) of the Active Medical Staff, amendments to these Bylaws and Rules and Regulations may be submitted to the Medical Staff and the Governing Body (and without the approval of MEC) for a vote. In such an event, the proposed amendments will be reviewed and considered at the next regularly scheduled meetings of the MEC and Governing Body prior to distribution to the Medical Staff. The MEC and the Governing Body have the right to have their comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

16.3. Method

16.3.1. Combined

The Medical Staff Bylaws may be adopted, amended, or repealed by the following combined action:

A. The affirmative vote of a majority of the Active Members of the Medical Staff who cast votes on the matter, provided at least fourteen (14) days advance notice accompanied by the proposed Bylaws or amendments (such notice and voting may be conducted electronically); and

B. The affirmative vote of a majority of the Governing Body.

16.3.2. Governing Body Vote

The Governing Body must vote on proposed amendments within forty-five (45) days from the date of receipt. If the Governing Body does not approve the proposed amendments, it must specify its reasons in writing and forward them to the Chief of Staff, the MEC, and the Bylaws Committee.

16.3.3. Approval of Amendments

Amendments must be approved by both the Medical Staff and the Governing Body before they take effect, excepting the situations set forth in Sections 16.4 and 16.5 herein.

16.4. Corrections

The MEC has the power to approve corrections, such as reorganization or renumbering of the Bylaws, or correcting punctuation, spelling, or other errors of grammar or inaccurate cross-references. Such amendments are effective immediately and are permanent. The action to make such corrections must be taken by motion and acted upon in the same manner as any other motion before the MEC. Substantive amendments are not permitted pursuant to this Section.

16.5. Urgent Amendments

In the case of a documented need for an urgent amendment to these Bylaws and Rules and Regulations necessary to comply with law, regulation, or deficiency issued by the Joint Commission or state of federal regulating body, the Rules and Regulations may be amended for

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that sole purpose by a two-thirds (2/3) affirmative vote of the MEC and by an affirmative vote of each Governing Body representative on the Joint Conference Committee. In such an event, the amendment must be submitted to the Medical Staff and Governing Body for retrospective review and approval, through the process outlined in this Article. This process must be initiated within 60 days of the Joint Conference Committee vote described in this Section. Per guidelines of The Joint Commission, Urgent Amendments to the Bylaws must follow the standard process for Bylaws Amendments as set forth in Articles 16.2 and 16.3 of these Bylaws. If there is a dispute regarding such an amendment, the Medical Staff may pursue the conflict management process set forth in Article 14 of these Bylaws.

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ARTICLE 17. MISCELLANEOUS PROVISIONS

17.1. Notice and Duty to Advise of Contact Information

Each Member, Affiliated Professional, or Applicant has an ongoing, affirmative duty to ensure that the MSSD has accurate contact information, including email address, personal telephone number, and mailing address, for that Member, Affiliated Professional, or Applicant. This duty includes the duty to promptly (within five (5) business days) update the MSSD of any changes to that contact information. For UCSF faculty or employees, the UCSF email address is considered to be the current contact information, although a Member, Affiliated Professional, or Applicant may provide an alternative/secondary email to the MSSD to use as well. For City employees, the City-provided email address is considered to be the current contact information, although a Member, Affiliated Professional, or Applicant may provide an alternative/secondary email to the MSSD to use as well.

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Except in relation to Notice related to Articles 6 and 7, above, any notification or other communication required by these Bylaws to be given by email is considered delivered when sent, and there is no obligation to ensure that such email is received or read by the Member, Affiliated Professional, or Applicant. However, if the MSSD receives a notification that an email is undeliverable, the MSSD will, within five (5) days, attempt to contact the Member, Affiliated Professional, or Applicant to obtain an accurate email address and/or to send the notification or other communication through alternative means to ensure the Member, Affiliated Professional, or Applicant learns of the issue.

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17.2. Sharing of Information for Disciplinary and Other Investigatory Purposes

During the course of Medical Staff processes outlined by these Bylaws, information may be obtained or disclosed that requires additional investigation outside of Medical Staff processes. By way of example and without limitation, information may be learned that relates to: unprofessional conduct of Hospital staff or people in other City or UCSF departments; alleged discrimination, harassment, or retaliation; patient privacy violations; patient abuse; an unsafe work environment; misuse of public resources; mistreatment of patients or other staff; fraudulent billing or other medical practices; medical malpractice; or other ethics or civil or criminal law violations. In each instance listed above, and in other instances as determined by the Chief of Staff or by any Medical Staff committee member or subcommittee member that learns such information, the Medical Staff, through the Chief of Staff or MSSD, must notify the Hospital Administration and the City Attorney's Office of the nature of the allegations or information within seven (7) days of learning such information in order to allow Hospital Administration and the City Attorney's Office to determine if a referral needs to be made to City and/or UCSF

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Human Resources departments, other City and/or UCSF departments, or law enforcement for a separate investigation for potential discipline or other purposes. Such disclosure may also be required by law or by Hospital, City, or UCSF policies or rules. The City Attorney's Office must be consulted if there is any question about what kind of information is to be disclosed.

In addition, there may be instances where parallel review or investigations occur related to the kinds of incidents or alleged misconduct listed in this section. By way of example, an incident might be submitted via a Safety And Feedback Events (SAFE) report (maintained by the Quality Management Department) that initially necessitates review by Risk Management, and the underlying information may quickly result in a referral for concurrent review by the Medical Staff, DPH or UCSF Human Resources, and/or the DPH Office of Compliance and Privacy Affairs. In the process of the investigation, the flow of information associated with these concurrent reviews can be complicated, and the City Attorney's Office should be consulted as early as possible to help ensure information only flows in the directions authorized by law and by DPH and Hospital policies. Each of these processes may result in a separate outcome, with distinct recommendations or action. Also, appropriate coordination between these separate processes can help ensure timely action that can correct issues that lead to errors, allow for improvement of clinical practice, result in appropriate regulatory reporting, and when needed result in disciplinary or other corrective action.

17.3. **Notice to MSSD and City Attorney's Office of Investigation by Professional Licensing Entity**

In the event that any Member or Affiliated Professional is given notice that the Member or Affiliated Professional is under investigation by any entity that has responsibility for issuance or oversight of the Member's or Affiliated Professional's professional license or certification (such as by the Medical Board of California, the Osteopathic Medical Board of California, or any other similar entity), the Member must give notice of such investigation within seven (7) days of learning of the investigation to the MSSD and the City Attorney's Office. Any request for medical records of any Hospital patient associated with any such investigation must be given to Hospital Health Information Systems for processing. In addition, the Member or Affiliated Professional must also promptly notify (within seven (7) days) the MSSD and City Attorney's Office any decision or action against the Member's or Affiliated Professional's license or certification by the entity conducting the investigation.

17.4. **Notice to MSSD and Chief of Service Regarding Action Against Privileges at Another Institution and Any Other Disclosable Event Related to Application/Reapplication for Privileges**

In the event that any Member or Affiliated Professional is given notice that their privileges have been suspended, restricted, or terminated at another institution for any amount of time, including voluntary acceptance of a suspension, restriction, or termination, for a medical disciplinary cause or reason, the Member or Affiliated Professional must inform the MSSD and the Member's Chief of Service within seven (7) days.

In the event that any Member or Affiliated Professional is the subject of any action listed in this paragraph, the Member or Affiliated Professional must inform the MSSD and the Member's Chief of Service within seven (7) days of the occurrence of that action or item. The items that are reportable to the MSSD and the Member's Chief of Service include all of the following:

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A. Actions related to the person's liability for or insurance coverage related to their professional activities, including: actions, arbitrations, claims, or lawsuits related to the provision of patient care; reporting of any professional liability claim to an insurance carrier; the making of any settlement, arbitration, decision, or judgment in any professional liability case in which the person or their insurer had to or agreed to make any monetary payment; denial, cancellation, or the threat of denial or cancelation of professional liability insurance coverage; or being named as a defendant in a malpractice case and then being dropped from the case.

A. Actions related to or that could impact patient care, including filing, withdrawal, or completion of any administrative, government, or court case or hearing involving allegations that the provider: failed to comply with laws, statutes, regulations, or other legal requirements related to the practice of their profession or provision of services to patients; violated of any criminal law (excluding minor traffic violations); was liable for any injury caused by the person's negligent or willful act or omission in rendering services; or was challenged or sanctioned regarding the person's admission, treatment, discharge, charging, collection, or utilization management related to patient care.

B. Actions or investigation (whether undertaken, pending, or completed) involving the denial, revocation, suspension, reduction, limitation, probation, non-renewal, or voluntary or involuntary relinquishment of the provider's: medical or affiliated staff membership at any facility; medical or affiliated staff privileges at any facility; provision of clinical care for ninety (90) days or more; status as a student in good standing in any program related to clinical practice; membership or fellowship in any local, county, state, regional, national, or international professional organization; faculty position or membership; specialty board certification; license or certificate to practice any profession in any state, country, or jurisdiction; or Drug Enforcement Administration or other controlled substances registration.

C. Any issue that impairs or could impair the person's ability to carry out their professional obligations in a manner that meets the standards of care in the community, under these Bylaws, or in relation to other Hospital policies, including: any physical or mental health condition or status; any communicable health conditions that could pose a significant health and safety risk to patients; or chemical dependency or substance abuse that might adversely affect the provider's ability to competently and safely perform the essential functions of a practitioner in their area of practice.

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THE PRISCILLA CHAN AND MARK ZUCKERBERG SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER

April 2026

Draft

MEDICAL STAFF BYLAWS

PREAMBLE

WHEREAS, The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center (ZSFG or Hospital) is a public hospital organized under the laws of the State of California and the Charter of the City and County of San Francisco; and

WHEREAS, its purpose is to serve as a general hospital providing patient care, research, and undergraduate and postgraduate education in the health sciences; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Governing Body, and that the cooperative efforts of the Medical Staff, the Hospital Administration and the Governing Body are necessary to fulfill the Hospital's obligations to its patients.

THEREFORE, the physicians, dentists, clinical psychologists, and podiatrists practicing in the Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws and Rules and Regulations. These Bylaws and Rules and Regulations provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with Applicants to, and Members of, the Medical Staff as well as with Affiliated Professionals whose clinical care is subject to Medical Staff oversight.

DEFINITIONS

Affiliated Professional: Individuals who are credentialed through the Medical Staff, are subject to general Medical Staff oversight, and belong to a professional category not eligible for Medical Staff Membership. They are not Members of the Medical Staff and are not afforded the due process rights set forth in these Bylaws, and they may not vote on amendments to the Bylaws or Rules and Regulations.

Attending Faculty or Attending: Member of the Medical Staff who meets the Bylaws board certification or eligibility requirements within their specialty and who supervises (or may supervise) physicians in training (residents or fellows), medical students and affiliated professionals (if required by their licensure). Attending physicians may also be faculty or volunteer faculty at University of California School of Medicine.

Applicant: Physician, dentist, podiatrist, or clinical psychologist who is applying for Medical Staff membership. To the extent applicable based on the context listed in these Bylaws, this term also applies in relation to people who are applying to be an Affiliated Professional.

Chief of Service: Each Member of the Active Medical Staff who is selected under Section 9.2 of these Bylaws to lead a Hospital clinical service and perform the duties listed in Section 9.3 of these Bylaws for that service. Each clinical service has a Chief of Service.

Chief of Staff: The Member of the Medical Staff who is elected as outlined by Article 8 of these Bylaws to serve as an officer of the Medical Staff and who serves as the head of the Medical Staff. The Chief of Staff has the powers and duties listed in Article 8 as well as elsewhere in these Bylaws.

City: The City and County of San Francisco.

Clean Application: An application for membership to the Medical Staff for which there is no missing information, all primary source verifications have been completed, and there are no

issues that raise concerns about the ethics, judgement, or quality of care of the application. The Chair of the Credentials Committee, in the Chair's sole discretion, will make the final determination as to whether the application is clean. Such applications may be approved by an email vote of the Credentials Committee and the Medical Executive Committee. Approval by the Governing Body must occur at a meeting of the Governing Body or a Committee of the Governing Body.

Clinical Service: A Hospital service group as listed in Article 9 of these Bylaws.

Date of Receipt: The date on which any Notice or other communication that was delivered personally or electronically, or three (3) days after it was postmarked.

Department Chair: The Chair of the Department at the University of California, San Francisco. For the Community Primary Care Service (CPC), the Director of Primary Care or their designee will act as the "Department Chair".

Director of Health: The Director of the San Francisco Department of Public Health, who also serves as a member of the Joint Conference Committee for Quality Assurance for the Hospital. The Director of Health will ensure that information that is required to be communicated to the Governing Body by these Bylaws will be communicated, and such information may be communicated to the Director of Health without jeopardizing any peer review protections.

Director of the San Francisco Health Network: The individual responsible for managing the delivery system of the Department of Public Health and who supervises the Hospital's Chief Executive Officer. Information required to be communicated to the Hospital's Chief Executive Officer may be communicated to the Director of the San Francisco Health Network without jeopardizing any peer review protections.

DPH: The San Francisco Department of Public Health.

Governing Body: The San Francisco Health Commission subject to the responsibilities designated to the Director of Health by the San Francisco Charter and Municipal Code.

Hospital: The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center.

Hospital Administration: Executive Staff Committee members, including the Hospital Chief Executive Officer, Senior Associate Administrators, and Associate Administrators appointed by the Director of Health or Hospital Chief Executive Officer, who implement the day-to-day operations of the Hospital.

House Staff: Trainees in Accreditation Council for Graduate Medical Education or American Board of Medical Specialties programs.

Joint Conference Committee for Quality Assurance (JCC): the committee where members of the Governing Body, Hospital Administration and Medical Staff review and discuss the Hospital's credentialing and quality assurance and performance improvement program.

Medical Staff: The organization established by these Bylaws and consisting of the collective group of Members duly appointed under these Bylaws and that takes action on behalf of Members as outlined by these Bylaws.

Medical Staff Services Department (MSSD): The hospital department that administratively supports medical staff activities.

Medical Staff Year: The period from July 1 through June 30.

Member: Physicians, dentists, clinical psychologists, and podiatrists whose applications have been approved by the Medical Executive Committee and the Governing Body for membership on the Medical Staff.

Practitioner: A neutral term used to describe either a Member of the Medical Staff or an Affiliated Professional as defined elsewhere in these Bylaws whose Clinical Privileges and Credentialing are governed by the Medical Staff Bylaws and Rules and Regulations

Notice: A written communication delivered personally, by email, electronically, or sent by United States mail regarding an appointment, reappointment, privileges, or Medical Staff status.

San Francisco Health Network (SFHN): The healthcare delivery system of the San Francisco Health Department. Hospital and community primary care are components of this delivery system that also includes skilled nursing care, mental health, substance abuse, and jail health services.

Staff: All people who work at the Hospital, whether as paid employees or volunteers of the City or UCSF or as contractors, including people who perform clinical, administrative, facility maintenance, or other duties.

University or UCSF: The University of California, San Francisco.

Vice Chair of a Medical Staff Committee: An individual who is subordinate to the Committee Chair and need not be a Member of the Medical Staff. The Vice Chair may chair Committee meetings and may represent the Committee at Medical Executive Committee meetings in the absence of the Chair.

Vice Dean: The UCSF Vice Dean located at the Hospital.

Note 1-Designation of "Acting" Executives – The terms "Chief of Staff," "Chief of Service," "Chief Executive Officer," "Vice Dean," and "Director of Health" include any persons designated to act on each person's behalf.

Note 2-Clarification of time-based definitions – All references to days in these Bylaws are to calendar days (not business days).

ARTICLE 1. NAME AND PURPOSES

1.1. Name

The name of this organization is the Medical Staff of The Priscilla Chan and Mark Zuckerberg San Francisco General Hospital and Trauma Center.

1.2. Purposes and Responsibilities

The purpose of the Medical Staff is to work with, and alongside, Hospital Administration and Staff to achieve the Hospital's True North (see Appendix 1). Specifically, the Medical Staff's purposes and responsibilities are to:

1.2.1. Collaborate

Collaborate with Hospital Administration to improve the services provided to patients;

1.2.2. Patient Care

Assure that all patients admitted to or treated in any of the facilities, departments or services of the Hospital receive care at a level of quality and efficiency consistent with generally accepted standards and attainable within the Hospital's means and circumstances;

1.2.3. Professional Performance

Assure a high level of professional performance of all Applicants authorized to practice in the Hospital through the appropriate delineation of the Clinical Privileges that each Applicant may exercise in the Hospital and through a continuing review and evaluation of each Applicant's performance in the Hospital;

1.2.4. Educational Setting

Provide an appropriate educational setting for continuing education of the Medical Staff and Affiliated Professionals and for the education of both undergraduate and graduate students in the health sciences;

1.2.5. Community Health Education

Organize and support community health education and support services;

1.2.6. Self-Governance

Develop and maintain Bylaws for self-governance of the Medical Staff;

1.2.7. Communication

Provide a means whereby issues of mutual concerns to the Medical Staff and Hospital Administration may be discussed by the Medical Staff with the Governing Body, the Chief Executive Officer, and the Director of Health;

1.2.8. Performance Improvement and Patient Safety

Incorporate the principles of performance improvement and patient safety in the provision of clinical care; and

1.2.9. Equity

Actively support the Hospital's commitment to equity in clinical, educational, and workplace relationships and systems.

ARTICLE 2. MEDICAL STAFF MEMBERSHIP

2.1. General Qualifications

Membership on the Medical Staff of the Hospital is a privilege that will be extended only to those Applicants who are professionally competent and continuously meet the qualifications, standards and requirements set forth in these Bylaws. Only those currently licensed physicians, dentists, clinical psychologists and podiatrists whose experience, training, ethics and demonstrated competence assure, in the judgment of the Medical Staff and the Governing Body, that any patient treated by them in the Hospital will receive quality medical care, may qualify for membership. Members of the Medical Staff must conduct themselves in the highest ethical tradition and in a manner consistent with the Code of Ethics of the American Medical Association, the American Dental Association, the American Psychological Association, the American Osteopathic Association, or the American Podiatric Medical Association. Individuals in administrative positions who desire Medical Staff membership or clinical privileges are subject to the same procedures as all other Applicants for membership or privileges.

2.2. Basic Qualifications for Consideration of Application For Active and Courtesy Medical Staff for Initial Appointment or Reappointment

To qualify for initial appointment or reappointment, an Applicant or Member or Affiliated Professional must demonstrate compliance with all the basic standards set forth in this Article 2 in order to have an application for Medical Staff membership accepted for review. The Applicant must meet the following standards:

2.2.1. Licensure

Physicians must (1) be licensed to practice medicine by the Medical Board of California or Osteopathic Medical Board of California or (2) comply with all of the requirements of California Business and Professions Code Section 2113 or Section 2168 *et seq*., including possession of a valid and current Certificate of Registration under those code sections and approval by the UCSF Dean, School of Medicine and the Vice Dean at the Hospital.

Dentists must be licensed to practice dentistry by the Dental Board of California.

Podiatrists must be licensed to practice podiatry by the California Board of Podiatric Medicine.

Clinical psychologists must be licensed to practice clinical psychology by the California Board of Psychology.

2.2.2. Drug Enforcement Agency (DEA)

Applicants must possess by their start date a valid federal DEA number unless the Applicant will never prescribe, or supervise the prescribing of, medications.

2.2.3. Physician Board Certification

A. Applicants must be certified or be progressing towards certification by (1) boards that are duly organized and recognized by an American Board of Medical Specialties (ABMS) or (2) a board or association with an Accreditation Council for Graduate Medical Education-approved postgraduate training that provides

complete training in that specialty or subspecialty. Applicants must become board certified before their first reappointment. In surgical specialties where case requirements must be met after training, exceptions may be made, but all applicants must achieve board certification no later than six years after the initial granting of Medical Staff membership. Re-applicants who have let their board certification lapse must become board certified no later than the second reappointment after their certification lapsed.

B. A Chief of Service may submit a written request for waiver of the certification requirement or an extension of the six-year period to become board certified to the Medical Executive Committee (MEC) for persons who demonstrate that their education, training, experience, ability, judgment, and medical skills make them sufficiently qualified to serve as Medical Staff Members. The MEC and the Governing Body will consider each request and determine whether approval is in the best interest of the patients and of the Hospital.

Persons appointed with an approved waiver as described above must be categorized with one of the following statuses:

1) Temporary Waiver
Temporary waivers are valid for the duration of the appointment or reappointment period. The temporary waiver is intended for people with a path to ABMS certification that is compatible with expectations and scope of their academic role and clinical duties. The person with the waiver is progressing toward certification by a board duly organized and recognized by the ABMS and must address their certification status at application for reappointment as outlined in this subsection 2.2.3.

2) Permanent Waiver
The waiver is permanent and automatically applies to future reappointments. The permanent waiver is intended for foreign trained providers that meet either of the below criteria:

a. Have no reasonably-feasible path to ABMS certification (*i.e.*, no path at all or a path to board certification that is either highly restrictive or would place undue burden on the individual and/or Clinical Service, significantly distracting from the Applicant's primary duties).

b. Are practicing medicine with the approval of the Medical Board of California pursuant to Section 2168 of the California Business and Professions Code.

2.2.4. Professional Liability Insurance

Individuals (both Members and Affiliated Professionals) who are not Members of the faculty of the University or are not employed by the City and County of San Francisco must maintain professional liability insurance in an amount not less than $2 million each occurrence, $6 million aggregate with an insurance carrier acceptable to the City's Risk Manager. Each such Member or Affiliated Professional must upon acceptance of the Medical Staff and thereafter at

any time requested by the Credentials Committee, provide the Credentials Committee with written evidence of conforming coverage. Each such individual must promptly report to the Credentials Committee any reduction, restriction, cancellation for termination of the required insurance coverage or, if applicable, change of insurance carrier. Insurance requirements set forth in these Bylaws are subject to review by the City's Risk Manager, and may be updated by the City's Risk Manager from time to time as conditions warrant. The insurance requirements of this section may be modified on a case-by-case basis for good cause by the Hospital's Chief Executive Officer in consultation with the City's Risk Manager and the Chief of Staff.

2.2.5. Participation in Medicare, Medicaid and Other Federal Health Care Programs

Applicants must:

A. Be eligible to participate in the Medicare, Medi-Cal, and other federal health care programs;

B. Obtain a National Provider Identifier (NPI); and

C. Enroll in Medicare and/or Medi-Cal and receive an enrollment confirmation letter, excluding dentists and other providers whose professional services are not reimbursed by Medicare and/or Medi-Cal, respectively.

2.3. Qualifications for Membership

In addition to meeting the basic qualifications, the Applicant must:

2.3.1. Experience, Education and Training

Document the Applicant's: (1) adequate experience, education, and training in the requested privileges; (2) current professional competence; (3) ability to perform the privileges requested; (4) good judgment; and (5) adequate physical and mental health to perform patient care activities, and demonstrate to the satisfaction of the Medical Staff that the Applicant is professionally and ethically competent to reliably provide the quality of care acceptable by the Medical Staff.

2.3.2. Ethics

Be determined: (1) to adhere to the lawful ethics of the Applicant's profession; (2) to work cooperatively with others in the Hospital setting so as not to adversely affect patient care or Hospital operations; and (3) to participate in and properly discharge Medical Staff responsibilities.

2.4. Condition and Duration of Appointment

2.4.1. Governing Body Action

Initial appointment and reappointment to the Medical Staff is made by the Governing Body. The Governing Body will act on appointments, reappointments, or revocation of appointments only after a recommendation from the Medical Staff as provided in these Bylaws.

2.4.2. Duration

Initial appointments and reappointments to the Medical Staff will each be for a period of not more than two (2) years.

2.4.3. Clinical Privileges

Appointments to the Medical Staff confer on the appointee only such Clinical Privileges as have been granted by the Governing Body, in accordance with these Bylaws.

2.4.4. Provide Care

Every Member will provide care and supervision of the Member's patients, abide by the Medical Staff Bylaws, accept committee assignments and, when appropriate, provide emergency service care and accept consultation assignments.

2.4.5. Non-Discrimination

Members must not discriminate in the provision of care to patients based on race, religion, color, national origin, ancestry, age, disability, medical status, sex, gender or sexual orientation, or any other basis prohibited by applicable local, state, or federal laws.

2.4.6. Division of Fees

The practice of division of fees under any guise whatsoever is prohibited and any such division of fees is cause for exclusion or expulsion from the Medical Staff.

2.5. Harassment Prohibited

Harassment by a Member against any individual (*e.g.*, against another Medical Staff Member, House Staff, Hospital personnel or patient) on the basis of race, religion, color, national origin, ancestry, age, disability, marital status, sex, gender or sexual orientation, or any other basis prohibited by applicable local, state, or federal laws will not be tolerated. All allegations of harassment will be investigated according to policies adopted by the City and/or University.

2.6. Nondiscrimination

No aspect of Medical Staff membership or Clinical Privileges and/or standardized procedures will be denied on the basis of race, religion, color, national origin, ancestry, age, disability, marital status, sex, gender or sexual orientation, or any other basis prohibited by local, state, or federal law. The credentialing and recredentialing processes will be conducted in a non-discriminatory manner and Members responsible for credentialing decisions will be required to sign an affirmative statement that they will make decisions in a non-discriminatory manner. Additionally, the Medical Staff must not discriminate with respect to staff privileges or the provision of professional services against a licensed physician and surgeon or podiatrist on the basis of whether the physician and surgeon or podiatrist holds an M.D., D.O., or D.P.M.

2.7. Effect of Other Affiliations

No person is entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely because the person holds a certain degree, is licensed to practice in this or any other state, is a Member of any professional organization, is certified by any Clinical Board, or because such person had, or presently has, staff Membership or privileges at another health care facility.

2.8. Basic Responsibilities of the Medical Staff

Each Medical Staff Member, Affiliated Professional and each Applicant exercising temporary privileges, must continuously meet all of the following responsibilities:

A. Provide the Member's or Affiliated Professional's patients with care that is of a generally recognized professional level of quality and efficiency;

B. Abide by the Medical Staff Bylaws and Rules and Regulations and all other lawful standards and policies of the Medical Staff and the Hospital;

C. Abide by applicable laws and regulations of government agencies, standards of the Joint Commission, and the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation;

D. Discharge such Medical Staff, Clinical Service, committee and service functions for which the Member, Affiliated Professional or Applicant exercising temporary privileges is responsible by appointment, election or otherwise; and

E. Complete new hospital orientation prior to exercising privileges.

F. Work cooperatively with Members, nurses, the Hospital Administration, and others so as not to adversely affect patient care or jeopardize the ability of the treatment team to provide quality patient care;

G. Report to their Service Chief any illness, disability, or absence which could affect patient care; and cooperate, at the Member's expense, with any health evaluations as may be reasonably required by the Medical Executive Committee;

H. Reporting to the Chief of Staff and their Service Chief within 7 days in the event of any formal action taken by government authorities to exclude the Member from participating in Medicare, Medicaid, or any other federal health care program;

I. Report to the Chief of Staff and their Service Chief within 7 days of: (1) any reduction, suspension, revocation, or termination of their Clinical Privileges and/or membership, for medical disciplinary cause or reason, at another licensed health care facility or medical group; (2) any certifying or licensing agency's initiation of an investigation, accusation, action, or settlement, (3) any surrender of license or certification, or (4) any felony charge or conviction of a misdemeanor or felony;

2.9. Non-Compliance With Basic Qualifications

An Applicant, Member or Affiliated Professional applying for reappointment who does not meet these basic qualifications is ineligible to apply for Medical Staff membership or reappointment and the application will not be accepted for review. If it is determined during the review process that an Applicant does not meet all of the basic qualifications, the review of the application will be discontinued. An Applicant who does not meet the basic qualifications is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific qualifications which adversely affected such Applicant, to the Credentials Committee.

Those comments and requests will be reviewed by the Credentials Committee and MEC, which has the sole discretion to determine whether the Applicant complies with the basic qualifications for Medical Staff membership.

ARTICLE 4. APPOINTMENT AND REAPPOINTMENTS

4.1. General

4.1.1. Application Process

All applications for appointment and reappointment to the Medical Staff or as an Affiliated Professional of the Medical Staff must be in writing, signed by the Applicant, and submitted to the Medical Staff Services Department (MSSD) on a form approved by the Governing Body, upon recommendation of the Credentials Committee.

4.1.2. Application Content

Every Applicant for appointment or reappointment must furnish a fully completed application, and has the burden of producing accurate and adequate information for a proper evaluation of the Applicant's current clinical competence, character, and ethics. Information in applications must include:

A. Any previous denial, revocation, suspension, reduction, limitation, probation, loss or relinquishment, whether voluntary or involuntary, to a professional license or DEA license;

B. Voluntary or involuntary termination of Medical Staff membership or Affiliated Professional status, or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital or other health care organization;

C. A factual synopsis of all pending and resolved professional liability actions, asserted or active within the previous five (5) years;

D. For any resolved professional liability actions, a description of the judgment, arbitration award, settlement or other disposition; and

E. Attestation responses regarding the following issues:

   1) Reason for an inability to perform essential functions of the position;

   2) Violations of any criminal law or statutes;

   3) Denial, revocation, suspension, reduction, limitation, probation, loss or relinquishment of licensure; and

   4) Disciplinary activity or limitation of privileges and/or Medical Staff status.

4.1.3. Completion of Application

An application is "completed" when the Applicant has supplied all of the requested information and all necessary verifications have been obtained—including, but not limited to, current license, licensing board disciplinary records, specialty Board Certification status,

National Practitioner Data Bank (NPDB) information, DEA certificate, if appropriate, training and practice from professional school through the present, current malpractice liability insurance and history, and reference letters, as specified in subsection 4.2.2 (Completed Application), below.

4.1.4. Application Misrepresentation or Omission

Any significant misrepresentation or omission by an Applicant for appointment or reappointment is grounds for denial of the application or other appropriate corrective action, including revocation of Clinical Privileges and Medical Staff membership.

4.1.5. Effect of Application

By applying for appointment or reappointment to the Medical Staff, each Applicant:

A. Signifies the Applicant's willingness to appear for interviews with the Medical Staff;

B. Authorizes the Medical Staff to consult with Medical Staff Members, administrators, or other personnel of other health care facilities with which the Applicant has been associated and who may have information bearing on the Applicant's competence, character, ethical qualifications, relevant mental and physical health, and any claims history;

C. Consents to the Medical Staff's inspection of all records and documents pertinent to the Applicant's current licensure, specific training, experience, current clinical competence and ability to perform the privileges requested and other matters that may be material to an evaluation of professional qualifications for Medical or Affiliated Staff membership;

D. Releases from any liability the Hospital, the Medical Staff, the Governing Body, the City, and the University, for any acts performed in good faith and without malice in connection with evaluating the Applicant's credentials; and

E. Certifies that the Applicant will promptly report to the MSSD any changes in the information submitted on the application which may subsequently occur.

4.1.6. Applicant's Right to Be Informed

Each Applicant has the right to be informed of the status of the Applicant's credentialing or recredentialing application upon request.

4.2. Initial Appointment Process

4.2.1. Applicant's Receipt of Medical Staff Information

The Applicant will be provided with a copy of, or access to, the Medical Staff Bylaws and Rules and Regulations, and Clinical Service Rules and Regulations governing the Applicant's specialty.

4.2.2. Completed Application

The completed application for initial appointment must include: detailed information concerning the Applicant's professional qualifications, including, but not limited to, education, professional training, experience, licensure, relevant physical and mental health, disciplinary history, claims history, information regarding possible involvement in professional liability actions, biographical data, requests for Clinical Privileges, peer references, health care facility affiliations, current professional insurance coverage, documentation of additional appropriate

licenses, certificates, or registrations required by law and/or the Medical Staff Bylaws and the appropriate Clinical Service Rules and Regulations, specialty board status, University faculty appointment status, and employment status; a signed agreement that the Applicant has read and will abide by the Medical Staff Bylaws and the appropriate Clinical Service Rules and Regulations; a release from liability for all parties engaging in good faith peer review, commencing with the credentialing process; and a signed statement of commitment to the confidentiality of all Medical Staff proceedings. It is the duty of the MSSD to provide an up to date copy of the Medical Staff Bylaws and the duty of the Clinical Service to provide an up to date copy of the Rules and Regulations to the Applicant for which the Applicant must attest.

4.2.3. Applicant's Burden and Incomplete Application

The Applicant has the burden of submitting complete, accurate, and adequate information for a proper evaluation of the Applicant's qualifications, including all requirements specified in the Medical Staff Bylaws, Medical Staff Rules and Regulations, and the Rules and Regulations of the department in relation to which that Applicant is seeking to work. This burden includes the burden of resolving any doubts about these matters and of providing any additional information requested by the Chief of Service, Chief of Staff, MSSD, or the Chair of the Credentials Committee. This burden also includes the Applicant paying any costs associated with verifications where the MSSD does not have access to the verification at issue. This burden may include submission to a medical, psychiatric, or psychological examination, at the Applicant's expense, if deemed appropriate by the MEC and, for City employees, as consistent with City rules. The Applicant's failure to sustain this burden or the provision of information containing any misrepresentations or omissions is grounds for denial of the application or subsequent termination, suspension, or limitation of Membership or Privileges under these Bylaws.

An incomplete application may not be processed. If an Applicant fails to complete the application within sixty (60) days after the date of initial submission, it may be considered voluntarily withdrawn on the sixtieth day after initial submission. If, prior to such voluntary withdrawal, the MSSD discovers that an application is incomplete, it will provide notice to the Applicant and the Chief of Service (or their designee) of the incomplete application as soon as possible (and no later than thirty (30) days before the deadline). Such voluntary withdrawal does not entitle the Applicant to the rights set forth in these Bylaws. The Credentials Committee may, for a good cause, extend the time for completion of the application.

4.2.4. Recommendation for Medical or Affiliated Staff Membership, and Clinical Privileges

When the MSSD has received all necessary verifications, the completed application, all supporting documentation, and other relevant information (collectively the "File"), it will submit the File to the Chief of Service for review and recommendations regarding membership and Privileges. The Chief of Service will then forward their written recommendations to the Credentials Committee. If the Applicant is seeking privileges in more than one Clinical Service, then the File will be submitted to all applicable Chiefs of Service for written recommendations once all verifications are received.

4.2.5. Credentials Committee Review and Action

The Credentials Committee will review the completed application and File and the Chief of Service's recommendations at the next regularly scheduled Credentials Committee meeting. The Credentials Committee, or a subcommittee thereof, may interview the Applicant if there are contents of the application or File that require clarification in person. The Credentials Committee will then submit to the MEC its written report and recommendations as to membership and Privileges.

4.2.6. Medical Executive Committee Review and Action

At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Committee, the MEC will review the Credentials Committee's report and recommendations and make a recommendation to the Governing Body, through the Director of Health, that the application be approved, denied, or deferred for further consideration. All recommendations to approve an application must also specifically recommend the Clinical Privileges to be granted and any special conditions or limitations relating to such Privileges. When the recommendations are adverse to the Applicant, the MEC will document the reasons for such recommendations in its minutes.

A. When the recommendation of the MEC is favorable to the Applicant, it will be forwarded to the Governing Body, through the Director of Health.

B. When the recommendation of the MEC is to defer the application for further consideration, the MEC must reconsider the application at its next regularly scheduled meeting.

C. When the recommendation of the MEC is adverse to the Applicant in respect to appointment or specific Privileges, the Chief of Staff will promptly notify the Division/Chief of Service. The Chief of Staff will also notify the Applicant by Notice in accordance with Section 7.3 of these Bylaws. The Governing Body will be generally informed of the recommendation for informational purposes, but it will not act on it

D. An Applicant who has received an adverse recommendation from the MEC as part of their initial appointment for privileges is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific qualifications which adversely affected such Applicant, to the Credentials Committee and MEC.

E. Those comments and requests will be reviewed by the Credentials Committee and MEC, which has the sole discretion to determine whether the Applicant should receive a favorable recommendation for Medical or Affiliated Staff membership.

4.2.7. Governing Body Review and Action

The Governing Body will act upon a favorable recommendation at its next regularly scheduled meeting and notify the Applicant of its decision. If the Governing Body's decision is adverse to the Applicant in respect to reappointment or Clinical Privileges, the Chief of Staff, upon receiving notice of the Governing Body's decision, will promptly notify the Applicant and Chief of Service of such adverse decision by Notice in accordance with Section 7.3 of these Bylaws. Such adverse decision will be held in abeyance until the Applicant has exercised, or has been deemed to have waived, the Applicant's procedural rights under Articles 6 and 7 of these

Bylaws. The fact that the adverse recommendation or decision is held in abeyance during the hearing and appellate review does not confer Privileges where none existed before, and any Privileges that have expired are not extended by such hearing or review.

A. In the event the Governing Body wishes to defer action, it may do so by referring the matter back to the MEC with a statement of its reasons for doing so. Any such referral to the MEC must set a time limit (not to exceed sixty (60) days) for the MEC to provide additional information or recommendations or take further action.

B. The final decision of the Governing Body must be made within forty-five (45) days of its receipt of the recommendation of the MEC. This final decision will be promptly forwarded to the MEC and the Applicant.

C. The time periods set forth in this section are guidelines only, not directives that create any right for an Applicant to have an application processed within these precise periods. When no time periods are specified, all parties will act as soon as reasonably practicable.

4.3. **Reappointment Process**

4.3.1. Frequency

The Medical Staff must reevaluate Members at least every two (2) years for the purpose of determining its recommendations for reappointment to the Medical or Affiliated Staff and the continuation of Clinical Privileges.

4.3.2. Reappointment Application Process

At least one hundred twenty (120) days before the expiration of a Member's appointment, the MSSD must email the Member a reappointment application. Within thirty (30) days of the date the application was emailed, the Member must return the completed application to the MSSD, along with all required information and materials.

4.3.3. Recommendation for Reappointment

Within thirty (30) days of the completed application for reappointment, the MSSD must email the completed application to the Chief(s) of the Service(s) in relation to which the Applicant is requesting Privileges. Each Chief of Service for a Service in relation to which the Member requests or has exercised Privileges must review the Member's completed File and forward the Chief of Service's written recommendations to the Credentials Committee. The recommendations will include a statement that the recommendations are based on the Clinical Service's performance improvement information for the Medical Staff Member or Affiliated Professional, any professional liability claims, the Member's clinical activity, education, and training, and any other pertinent information. The Chief of Service(s) must return the application with written recommendation no less than sixty (60) days before the expiration of the Member's appointment.

In addition to the items listed in this subsection 4.3.3, each recommendation concerning reappointment of a Member and the Clinical Privileges to be granted upon reappointment must be based upon such Member's current professional performance including, but not limited to, ongoing Professional Practice Evaluation (OPPE) data, performance reviews, evidence of progression towards Board Certification or re-certification (if applicable), current competence, clinical or technical skills and judgment in the treatment of patients, ongoing provider specific continuous quality improvement evaluations, ethical conduct, attendance at Medical Staff

meetings and participation in Medical Staff affairs, compliance with these Bylaws and Rules and Regulations, voluntary or involuntary loss and/or relinquishment of Privileges or licensure, results from the National Practitioner Data Bank inquiry, and mental or physical health that permits the Member to carry out the essential functions of the Member's Medical Staff category,Privileges, or Standardized Procedures with or without reasonable accommodation.

4.3.4. Credentials Committee Review and Action

The Credentials Committee will review the completed application and File and the Chief of Service's recommendations at the next regularly scheduled Credentials Committee meeting. The Credentials Committee, or a subcommittee thereof, may interview the Applicant if there are contents of the application or File that require clarification in person. The Credentials Committee will then submit to the MEC its written report and recommendations as to membership and Privileges.

4.3.5. Medical Executive Committee Review and Action

At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Committee, the MEC will review the Credentials Committee's report and recommendations and make a recommendation to the Governing Body, that the application be approved, denied, or deferred for further consideration. All recommendations to approve an application must also specifically recommend the Clinical Privileges to be granted and any special conditions or limitations relating to such Privileges . When the recommendations are adverse to the Applicant, the MEC will document the reasons for such recommendations in its minutes.

D. When the recommendation of the MEC is favorable to the Applicant, it will be forwarded to the Governing Body.

E. When the recommendation of the MEC is to defer the application for further consideration, the MEC must reconsider the application at its next regularly scheduled meeting.

F. When the recommendation of the MEC is adverse to the Applicant in respect to reappointment or Clinical Privileges, the Chief of Staff will promptly notify the Division/Chief of Service. The Chief of Staff will also notify the Applicant by Notice in accordance with Section 7.3 of these Bylaws. The Governing Body will be generally informed of the recommendation for informational purposes, but it will not act on it until after the Applicant has exercised, or has been deemed to have waived, the Applicant's procedural rights set forth in Articles 6 and 7 of these Bylaws.

4.3.6. Governing Body Review and Action

The Governing Body will act upon favorable recommendation at its next regularly scheduled meeting and notify the Applicant of its decision. If the Governing Body's decision is adverse to the Applicant in respect to reappointment or Clinical Privileges, the Chief of Staff, upon receiving notice of the Governing Body's decision, through the Director of Health, will promptly notify the Applicant and Chief of Service of such adverse decision by Notice in accordance with Section 7.3 of these Bylaws. Such adverse decision will be held in abeyance until the Applicant has exercised, or has been deemed to have waived, the Applicant's procedural

rights under Articles 6 and 7 of these Bylaws. The fact that the adverse recommendation or decision is held in abeyance during the hearing and appellate review does not confer Privileges where none existed before, and any Privileges that have expired are not extended by such hearing or review.

G. In the event the Governing Body wishes to defer action, it may do so by referring the matter back to the MEC with a statement of its reasons for doing so. Any such referral to the MEC must set a time limit (not to exceed sixty (60) days) for the MEC to provide additional information or recommendations or take further action.

H. The final decision of the Governing Body must be made within forty-five (45) days after additional information is provided by MEC. This final decision will be promptly forwarded to the MEC and the Applicant.

I. The time periods set forth in this section are guidelines only, and are not directives that create any right for an Applicant to have an application processed within these precise periods. When no time periods are specified, all parties will act as soon as reasonably practicable.

4.3.7. Term of Reappointment

Reappointments to any Medical Staff category will be for a maximum of two (2) years.

4.3.8. Failure to Return a Completed Reappointment Application

If the Member has not returned a completed reappointment application to the MSSD within thirty (30) days of the email required under subsection 4.3.2, above, then the MSSD will email a final reminder allowing a fifteen (15) day extension from the date of the reminder email. Failure of a Medical Staff Member or Affiliated Professional to return a completed application for reappointment at least seventy-five (75) days prior to the expiration of the Member's current term may result in automatic resignation of the Member's Privileges effective on the date the Member's current term expires. The respective Chief of Service will be notified in writing of the delinquent reappointment and pending termination. After the passing of the 15-day extension period and after the Chief of Service is notified, the MSSD will check with the Chief of Service regarding the status of the Member's Privileges, including regarding any discussion of submission of the reappointment application. If no progress has been made by the Member in addressing the reappointment application submission, the MSSD will forward information about the potential automatic resignation of the Member's Privileges to the Credentials Committee for review and a final decision regarding the automatic resignation. A Member who automatically resigns under this section will be processed as a reappointment if the Member submits a completed reappointment application within thirty (30) days from the date of termination.

4.3.9. Reapplication After Adverse Decision

An Applicant or Member who has received a final adverse decision regarding appointment, reappointment, membership, Privileges, or who has resigned after notice of an adverse recommendation or a final adverse decision, is not eligible to reapply to the Medical or Staff or for appointment as an Affiliated Professional for a period of two (2) years from the date of the final adverse decision or resignation. Thereafter, the Applicant may apply as a new

Applicant and must submit information to demonstrate that the basis for the earlier adverse decision or recommendation no longer exists.

4.4. Access to Own Credentials File

Each Member will be provided with access to information in the Member's own credentials file subject to the following provisions:

A. The Member may receive a copy of only those documents provided by or addressed to the Member as well as all Ongoing Professional Practice Evaluation and/or Focused Professional Practice Evaluation reports (OPPE and FPPE reports, respectively); and

B. A summary of peer review information, committee findings, letters of reference, proctoring reports, and complaints will be provided to the Member by the Chief of Staff within thirty (30) days of receipt of such a request. Summaries of peer review materials will disclose the substance, but not the source, of the information.

4.5. Right to Request Corrections/Additions

Members may exercise the right to request corrections or additions to their credentials file following the protocol set forth below:

A. Members have the right to add to the Member's own credentials file a statement responding to any information contained in the file;

B. A Member may submit a written request to the Chief of Staff for the correction or deletion of information in the credentials file. Such requests must include a statement of the basis for the action requested;

C. The Chief of Staff will recommend to the MEC whether or not to make the requested correction or deletion;

D. The MEC will approve or deny the Chief of Staff's recommendation by a majority vote; and

E. The Member will be notified by the Chief of Staff of the decision of the MEC. The decision of the MEC is final.

4.6. House Staff

House Staff are not eligible for Medical Staff membership.

4.7. Affiliated Professionals

4.7.1. General

A. Affiliated Professionals are individuals who:

   1) Are employees of the City, or faculty or employees of the University, or functioning under an MOU approved by the MEC and Governing Body, and provide health services requiring them to exercise independent judgment within the area of the Affiliated Professional's professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable State laws;

   2) Do not qualify for Medical Staff membership because they are not licensed as physicians, dentists, clinical psychologists, or podiatrists; and

3) Belong to one of the following professional categories:
    - Licensed Acupuncturists
    - Certified Nurse Midwives
    - Certified Registered Nurse Anesthetists
    - Nurse Practitioners
    - Physician Assistants
    - Clinical Pharmacists (PharmD)
    - Optometrists
    - Genetic Counselors.

B. Although not eligible for Medical Staff membership, Affiliated Professionals are credentialed through the Medical Staff and are subject to general Medical Staff oversight.

C. The clinical responsibilities of each Affiliated Professional must be set forth in privileges developed by the Committee on Interdisciplinary Practice and approved by the Credentials Committee, MEC, and the Governing Body. Note that any reference in these Bylaws to privileges for Affiliated Professionals includes both concepts as appropriate for the situation.

4.7.2. Role of Medical Staff

A. Affiliated Professionals practice within the scope of the Affiliated Professional's licensure and as otherwise consistent with applicable Hospital and Medical Staff policies, procedures, or privileges. To the extent that state regulations require supervision of Affiliated Professionals beyond overall Medical Staff oversight, the additional supervisory relationship will occur as required by law.

B. As employees of either the City or the University, Affiliated Professionals are recruited and hired through the usual personnel processes of each respective employing entity. Any clinical activity is contingent upon Medical Staff approval following the procedures set forth below.

4.7.3. Appointment

A. Each Affiliated Professional who has been provisionally hired must submit an application to the MSSD for appointment to Affiliated Professional status. The Applicant must furnish all information required on the application form or reasonably requested by the Interdisciplinary Practice Committee, Credentials Committee, or the MEC. The Applicant has the burden of producing adequate information for a proper evaluation of competency, character, and ethics. An Applicant who fails to provide all requested information within thirty (30) days of the date of being notified of any deficiencies will be deemed to have withdrawn the application.

B. An Applicant who is on the Office of Inspector General (OIG) Exclusion List is not eligible for appointment as an Affiliated Professional.

C. An Applicant must possess a National Provider Identifier (NPI) or must have submitted an application for an NPI in order to be considered for appointment or reappointment as an Affiliated Professional.

D. An Applicant must possess a DEA certificate or have submitted the application for a DEA certificate unless the Applicant will be working in an area where no medications are prescribed (such as Radiology or Pathology) or whose licensure does not allow prescribing medications.

E. An Applicant must have enrolled in Medicare and received an enrollment confirmation letter, excluding PharmDs whose professional services are not reimbursed by Medicare and Nurse Practitioners hired prior to April 2004 without a master's degree.

F. Nurse Practitioners hired by the City or University after April 2004 must have a master's degree in nursing and be board-eligible.

G. The MSSD will forward the completed application to the Chair of the Interdisciplinary Practice Subcommittee of the Credentials Committee. The Interdisciplinary Practice Subcommittee will review the application and will forward the application together with its recommendation to the Credentials Committee.

H. The Credentials Committee will review the application and make a recommendation to the MEC.

I. The MEC will review the recommendation of the Credentials Committee and make a recommendation to the Governing Body.

J. The Governing Body will review the recommendation of the MEC and will make a decision whether to approve the Affiliated Professional.

K. If the Governing Body denies the Applicant's admission to Affiliated Professional status, the Applicant is limited to the remedies set forth in the Grievance Procedures in the applicable Memorandum of Understanding. The Applicant is not entitled to any of the procedural rights set forth in these Bylaws.

L. Services that require a privilege or standardized procedure may not be performed until the Applicant's credentials and privileges or appointment have been approved by the Medical Staff.

M. An Affiliated Professional who is admitted to Affiliated Professional status is subject to a period of proctoring/evaluation under rules and procedures established by the relevant clinical service.

N. By applying for Affiliated Professional status, the Applicant must comply with and agrees to the same provisions that apply to Applicants for Medical Staff membership set forth in the following Sections and subsections of these Bylaws:

    a. Subsection 2.2.4 (Professional Liability Insurance);

    b. Subsection 2.2.5 (Participation in Medicare, Medicaid and other Federal Health Care Programs);

    c. Section 2.3 (Qualifications for Membership);

    d. Section 2.5 (Harassment Prohibited);

    e. Section 2.8 (Basic Responsibilities of the Medical Staff);

O. Subsection 4.1.3 (Completion of Application);

a. Subsection 4.1.4 (Application Misrepresentation or Omission); and

P. Subsection 4.1.5 (Effect of Application).

Q. Any material misrepresentation by an Applicant is grounds for denial of the application or for termination of Affiliated Professional status.

4.7.4. Reappointment

A. The initial appointment to Affiliated Professional status will last for a maximum period of two (2) years.

B. Each subsequent reappointment will be for a maximum two (2) year period.

C. Prior to the end of each appointment or reappointment period, the MSSD will provide the Affiliated Professional with an application for reappointment, and the application for reappointment must be submitted and processed according to the same procedures as for the initial appointment and is subject to the same restrictions.

4.7.5. Corrective Action

A. Any corrective employment action against an Affiliated Professional must be done in accordance with the procedures set forth in the applicable City or University employment Memorandum of Understanding (MOU) or other applicable employment policies and rules. The Affiliated Professional is not be entitled to any of the procedural rights set forth in these Bylaws.

B. In the event that immediate action is necessary to prevent imminent danger to the health or safety of any individual, the Affiliated Professional's right to perform some or all duties set forth in their Job Description may be suspended immediately, in accordance with the procedures set forth in the applicable MOU. In addition, any clinical privileges or standardized procedures exercised by an Affiliated Professional that is overseen by the Medical Staff may be addressed by the Medical Staff using concepts similar to those listed in Article 6 (Corrective Action) of these Bylaws at the discretion of the Chief of Staff or MEC without affording the Affiliated Professional any procedural rights listed in Article 6. Similarly, the Chief of Service may, in consultation with the Chief of Staff, address allegations of inappropriate behavior by Affiliated Professionals using the concepts listed in this subsection 6.2.2, although there are no specific requirements of using any specific concept or process listed in this section. An Affiliated Professional is not be entitled to any of the procedural rights set forth in these Bylaws.

ARTICLE 5. CLINICAL PRIVILEGES

5.1. Clinical Privileges

5.1.1. Process

Members and Affiliated Professionals are entitled to exercise only those Clinical Privileges specifically granted to them by the Governing Body except as provided in Section 5.2 herein regarding temporary privileges, or to practice within . The granting of Privileges depends upon an individual's documented experience in categories of diagnostic and treatment areas and current competence as judged by ongoing continuous quality improvement reviews. The Rules and Regulations of each Clinical Service specify the Clinical Privileges for that Service.

Clinical Privileges or appointment with Standardized procedures are required for the provision of telehealth services. Specific privileges may cover the provision of both in-person and telehealth services. Privileges or standardized procedures for Members or Affiliated Professionals who provide only telehealth services are subject to the same requirements that apply to all privileges.

5.1.2. Education, Training and Experience

Every initial application for Medical Staff or Affiliated Professional appointment must contain a request for specific Clinical Privileges desired by the Applicant. The evaluation of such requests must be based upon the Applicant's documented education, training, experience and demonstrated competence, University faculty appointment (if applicable), references, and other relevant information, including a recommendation by the Chief of Service in which such Privileges are sought. The Applicant has the burden of demonstrating qualifications and competency in the requested Clinical Privileges or Appointment as an Affiliated Professional.

5.1.3. Evaluation

Ongoing monitoring of Clinical Privileges is based on a variety of modalities which can include but not be limited to direct observation of the care provided, review of medical records, and other peer review activities.

5.2. Temporary Appointments with Clinical Privileges

5.2.1. Pending Application for Permanent Medical or Affiliated Staff Membership

A. In the event that there is a compelling patient care need which the Chief of Service could not have anticipated, the Chief of Staff in consultation with both the CEO (or designee) and the Chair of the Credentials Committee, may grant temporary appointment with Privileges to an Applicant who has a Clean Application ~~Credentials~~ is pending the next meeting of the Governing Body for final approval.

B. No person with Temporary Privileges or Affiliate status may vote or hold office.

C. Temporary Privileges or Temporary Affiliate status may be granted for a period not to exceed sixty (60) days.

5.2.2. Application and Review

The Chief of Staff, with the concurrence of the Chief Executive Officer, may grant Temporary Privileges or Temporary Affiliate status after the following has been completed:

A. The Chair of the Credentials Committee has determined that the Applicant has a "Clean Application" as defined in the Definition section of these Bylaws.

B. The Chief of Service provides the Chief of Staff with a compelling patient care need that could not have been anticipated and that requires that the services of the Applicant begin before the application can be approved at the next meeting of the Governing Body.

5.2.3. General Conditions

A. There is no right to Temporary Privileges or Temporary Affiliate Status. They may be granted at the sole discretion of the Chief of Staff only after a Clean Application has been approved by the Chair of the Credentials Committee .

B. A determination to grant Temporary Privileges or Temporary Affiliate Status is not binding or conclusive with respect to an Applicant's pending request for appointment to the Medical or Affiliated Staff.

C. In exercising Temporary Privileges or Standardized Procedures, the Applicant will act under the supervision of the Chief of Service, or designee, to whom the Applicant is assigned and will be proctored and monitored in accordance with the Clinical Service Rules and Regulations and the proctoring provisions set forth in these Bylaws.

D. Temporary Privileges or Temporary Affiliate Status will not be granted unless the Applicant has an academic appointment with the University, is an employee of the City, or provides documentation of professional liability insurance coverage in accordance with subsection 2.2.4 of these Bylaws.

E. Temporary Privileges or Temporary Affiliate Status will not be granted unless the Applicant signs an acknowledgment that the Applicant has received, or been given access to, a copy of the Medical Staff Bylaws and agrees to be bound by the Bylaws.

F. The Chief of Staff may use the Chief's discretion to restrict, suspend, or terminate any or all of the Temporary Privileges or Standardized Procedures granted. In such an event, the Member Applicant is not entitled to the procedural rights set forth in Article 6 of these Bylaws, or to any other procedural rights, unless such action requires the filing of a report to either the Member Applicant's professional licensing organization (such as the Medical Board of California) or the National Practitioner Data Bank.

5.3. **Visiting Privileges**

5.3.1. To Meet a Specific Need

G. Visiting Privileges may be granted for a specified period of time, not exceeding ninety (90) days, on a case-by-case basis when a patient (or patients) of a Clinical Service requires the services of a physician, dentist, podiatrist, or clinical psychologist who is not a Member of the Medical Staff. If the individual with Visiting Privileges desires to join the Medical Staff, the individual must submit an application as a new appointment. No person with Visiting Privileges may vote or hold office. (Note: ZSFG Administrative Policy 22.06 refers to this position as "Consulting Clinical Physician".) The Chief of Staff, with the concurrence of the Chief Executive Officer, may authorize Visiting Privileges if:

1) The person has submitted a completed application for Visiting Privileges or Affiliated Professional Status;

2) The Chief of Staff reasonably believes that the person has the qualifications, ability, and judgment required for Medical or Affiliated Staff membership;

3) The Chief of Service requiring a person's services recommends the person; and

4) The Chief of Service has provided, in writing, the clinical need for granting such Privileges.

5.3.2. General Conditions

A. In exercising Visiting Privileges, the Applicant must act under the supervision of the Chief of Service, to which the Applicant is assigned.

B. Visiting Privileges or Affiliate Status must not be granted unless the Applicant has an academic appointment with the University, is an employee of the City, or provides documentation of professional liability insurance coverage in accordance with subsection 2.2.4 of these Bylaws.

C. Visiting Privileges or Affiliate Status will not be granted unless the Applicant signs an acknowledgment that the Applicant has received, or been given access to, a copy of the Medical Staff Bylaws and agrees to be bound by them.

D. The Chief of Staff may use the Chief's discretion to restrict, suspend, or terminate the Visiting Privileges or Affiliate Status. In such an event, the provider is not be entitled to the procedural rights set forth in Articles 6 and 7 of these Bylaws, or to any other procedural rights, unless such action requires the filing of a report to either the Member Applicant's professional licensing organization (such as the Medical Board of California) or the National Practitioner Data Bank.

E. The Chief of Staff will present the candidate to the Governing Body for approval with a rationale regarding why Visiting Privileges or Affiliate Status should be granted.

F. All requirements of ZSFG Administrative Policy 22.06 (including as it is amended in the future) must be met.

5.4. Emergency Situations and Privileges or Affiliate Status

5.4.1. Emergency Situations When More Qualified Healthcare Personnel Are Not Available

In the event of an emergency, any qualified Member or Affiliated Professional is allowed to do everything reasonable to save the life of a patient or to save a patient from serious harm. The Member or Affiliated Professional must promptly yield such care to more qualified healthcare personnel when available.

5.4.2. Emergency Situations Pertaining to a Single Patient or a Few Patients

In the event of an emergency or critical situation where no Member or Affiliated Professional possesses the expertise necessary to save the life of a patient or to save a patient from serious harm, the Chief of Staff may grant emergency Privileges or Affiliate Status to a licensed Practitioner, who has an academic appointment with the University and who possesses the requisite qualifications and expertise to treat the patient or a few patients, at the discretion of the Chief of Staff. In the event that no qualified Practitioner with an academic appointment at the University is available within the necessary clinical time frame, the Chief of Staff may grant emergency Privileges or Affiliate Status to a Practitioner with a license recognized by the state of California who possesses the requisite qualifications and expertise to treat the patient(s). Care provided under emergency Privileges or Affiliate Status will be documented in the hospital medical record related to each patient treated by that provider, and a record of the Practitioner's emergency Privileges or Affiliate Status will be maintained by the MSSD, including the Practitioner's name and license, the name and medical record number of any patients treated by that Practitioner, and the dates of service. MSSD will perform primary source verification of the medical license and verification of malpractice coverage as soon as possible.

5.4.3. General Emergency Situations

General emergency situations may arise due to a disaster, such as an earthquake, weather emergency, or fire, due to an infectious disease, due to an extreme staffing shortage, or due to other circumstances. Any time such a general emergency situation arises, including but not limited to any time the Hospital activates its Emergency Management Plan, Members and Affiliated Professionals who are qualified based on training or experience may perform expanded roles outside the scope of their normal Privileges or Standardized Procedures at the discretion of the Chief of Staff in consultation with leadership from the affected clinical service areas without requiring that new Privileges be granted. The clinical services being supported by such qualified Members and Affiliated Professionals will provide any additional orientation or training that is necessary and ongoing supervision and oversight of the provider during the emergency. Services provided in relation to such general emergency situations are subject to the following requirements based on the duration of the emergency:

A. Emergency Privileges or Affiliated Status for Service Less than One Month

1) In the event Practitioners present themselves to the Hospital during an emergency, including but not limited to when the Hospital activates its Emergency Management Plan, and the Hospital is unable to handle the immediate patient needs, Emergency Privileges or Affiliated Status may be granted by the Chief Executive Officer, the Chief of Staff, the Chief Executive Officer's designee(s), or the Chief of Staff's designee(s) to providers for services less than one month in duration upon presentation of the following information, with a record to be kept by the MSSD when feasible:

a. A valid government-issued photo identification card such as a driver's license or a passport, and

b. At least one of the following:

i. A copy of a current license to practice;

ii. Primary source verification of licensure;

iii. Identification indicating that the individual is a Member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;

iv. Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in emergency circumstances; or

v. Confirmation by a Member or an Affiliated Professional with personal knowledge of the volunteer provider's ability to act as a licensed independent provider during an emergency.

2) During the emergency, the Medical Staff will oversee the performance of each Practitioner who has been granted emergency privileges or Affiliated Status. Based on its oversight of such Practitioner, the Medical Staff will determine within seventy-two (72) hours, and on an ongoing basis as needed after that, of the Practitioner's arrival if the emergency privilege should continue. Practitioners granted emergency Privileges or Affiliated Status must document the care they provide in a manner similar to Members of the Medical Staff when feasible.

3) Primary source verification of licensure and confirmation of malpractice coverage must occur as soon as the emergency is under control or within seventy-two (72) hours from the time the provider presented to the Hospital, whichever comes first. If verification cannot be completed within seventy-two (72) hours due to extraordinary circumstances, the following must be documented and maintained by the MSSD:

   a. The reason(s) verification could not be performed within seventy-two (72) hours;

   b. Evidence of the provider's demonstrated ability to continue to provide adequate care, treatment, and services; and

   c. Evidence of the Hospital's attempt to perform primary source verification as soon as possible.

   Primary source verification of licensure is not required if the provider has not provided care, treatment, or services under the emergency Privileges or Standardized Procedures.

4) When additional assistance is required by a clinical service due to an extreme staffing shortage and an outside provider is identified who can capably perform the required duties, the Chief of Staff may grant emergency Privileges or Affiliate Status to be overseen by the clinical service and Chief of Service or the Chief of Service's designee. The MSSD will keep a record confirming the Chief of Service's or designee's agreement to the appointment and attestation that the provider can adequately perform the necessary clinical care. The MSSD will determine the source of the provider's malpractice coverage, the provider will be granted access to the Hospital's medical record system, and the provider will be given Hospital identification.

B. Emergency Privileges or Affiliate Status for Service More than One Month

The Medical Staff or Affiliated Professionals will use Emergency Privileges or Standardized Procedures using the procedures described above for emergency service less than one month. Once Hospital Leadership or the Chief of Staff determine that emergency service will be needed for more than one month, the Medical Staff will, within one month of emergency Privileges or Affiliate Status being granted to the provider, request that the provider apply for regular Hospital Privileges or Affiliate Status. If the provider declines to apply for regular Privileges or Affiliate Status, the Chief of Staff or designee may extend Emergency Privileges or Affiliate Status for a maximum of three additional months, for a total of no longer than four months of emergency privileges for that provider in most situations. The Chief of Staff may extend emergency privileges to cover the time period while the application for regular Hospital privileges is in process, which should not generally exceed three months from the time the provider submits the application. For Emergency Privileges or Affiliate Status longer than one month, the Chief of Staff will update the Governing Body of such Emergency Privilege or Affiliate Status s.

5.5. Visiting Physicians and other Categories of Practitioners

ZSFG Administrative Policy 22.06 "Visiting Physicians" (see Appendix 2) defines "Consulting Clinical Physician", "Consulting Academic Physician", "Physician Observer", and "Visiting Research Physician". Physicians in these roles and Practitioners who would fall within

the category of Affiliated Staff do not have Privileges or Standardized Procedures unless specifically granted under Section 5.3, above, may not direct patient care, do not have access to medical records, and must follow all requirements of ZSFG Administrative Policy 22.06.

for their specific category regarding:

A. Their role in interacting with the patient and Members.

B. Maintenance of professional liability coverage must be either through their primary institution or own insurance company.

C. Sponsorship by the Chief of the sponsoring Clinical Service, or for Visiting Research Physicians, the Principal Investigator with the consent of the Chief of Service.

D. Immunizations—if in patient care settings, must meet same requirements as clinical staff.

E. Orientation as applicable for the specific category.

F. Identification badges if in patient care areas.

G. Required patient consent if interacting with or observing patients.

5.6. **Proctoring**

5.6.1. General

All new appointees to the Medical and Affiliated Staff and existing Members requesting additional Privileges or Standardized Procedures, regardless of specialty or category of membership, will be assigned a Proctor by the Chief of Service and complete a period of proctoring, as defined in subsection 5.6.4, below.

The Proctor must have unrestricted Privileges or Standardized Procedures to perform the evaluation(s) that the Proctor will conduct. The Chief of Service will submit a form to the Credentials Committee attesting to the satisfactory completion of proctoring. Documentation of the proctoring will reside in the Clinical Service Office.

5.6.2. Function and Responsibility of the Proctor

H. The Proctor is responsible for evaluating the provider's clinical competence for the requested privileges or standardized procedures.

I. The Proctor's primary responsibility is to evaluate the Proctoree's performance. However, if the Proctor believes intervention is warranted in order to avert harm to a patient, the Proctor may take any action the Proctor finds reasonably necessary to protect the patient.

5.6.3. Responsibility of the Proctoree

The Proctoree is responsible for notifying one of the assigned Proctors for each patient whose care is to be evaluated. For surgical or invasive medical procedures that will be observed, the Proctoree is responsible for arranging the time of the procedure with the Proctor.

5.6.4. Proctoring Duration

Proctoring will be deemed successfully completed when the Proctoree completes the proctoring as described in the Clinical Service Rules and Regulations. Proctors may begin proctoring upon initial granting of Privileges or Affiliate Status with the goal of completing

proctoring within the first six months after the initial grant, but in any case must complete proctoring within the first twelve (12) months of initial granting of new Privileges or Affiliate Status .

For Privileges or Standardized Procedures that are infrequently performed by the Member, the Chief of Service may submit a written request to the Credentials Committee to expand the proctoring period. Alternatively, the Chief of Service may request that proctoring occur at another accredited hospital. These Privileges or Standardized Procedures must be voluntarily relinquished or withdrawn if proctoring is not completed within twenty-four (24) months of the initial granting of the infrequently performed Privileges or Standardized Procedures unless the MEC and the Governing Body approve an extension.

5.6.5. Reciprocal Proctoring

Reciprocal proctoring is proctoring that is performed by non-Hospital Members at sites other than the Hospital. Reciprocal proctoring may be accepted when no Hospital Members who possess the necessary expertise are available to proctor a specific skill or procedure. Only such specific skills or procedures may be reciprocally proctored; all other elements of the Applicant's practice must be proctored by a Medical or Affiliated Staff Member of the Hospital. Requirements for reciprocal proctoring are as follows:

J. The reciprocal Proctor is an active member of the medical or affiliated staff at another accredited hospital;

K. The reciprocal Procter possesses unrestricted Privileges to perform the procedure for which the proctoring is being performed; and

L. The Chief of Service has approved the reciprocal proctoring arrangement and the reciprocal Procter.

For each case that is reciprocally proctored, the reciprocal Proctor must complete a Hospital proctoring form and submit it to the Clinical Service. The Clinical Service will submit an evaluation summary to the Credentials Committee.

MEDICAL STAFF BYLAWS

ARTICLE 6. MONITORING AND CORRECTIVE ACTION

6.1. Routine and Issue-Related Monitoring

6.1.1. Routine Monitoring and Education, Including Verbal and Written Counseling

Responsibilities of the Chiefs of the Clinical Services include:

A. Ensuring the quality of patient care rendered by their service and maintaining professional standards of behavior among Members and Affiliated Professionals (Practitioners) of their service. Academic performance or University employment are University matters and City employment is a City matter, and those matters are not addressed in these Bylaws.

B. Quality of Patient Care - Education, Monitoring and Investigation and Response to Concerns Identified.

C. Carrying out peer review and quality improvement functions for their service. The Chief of Service may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the Practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. The Practitioner will be given an opportunity to respond in writing and to discuss the matter with the Chief of Service. The Chief of Service will maintain documentation of any informal actions, monitoring, or counseling.

6.1.2. Focused Professional Practice Evaluation

A. The Focused Professional Practice Evaluation (FPPE) is a process required by the Joint Commission for evaluation by the Medical Staff of the privilege-specific competence of the provider who does not have documented evidence of competently performing the requested privilege(s) at the Hospital, whether at the time of application or on reappointment. Per the Joint Commission, this process may also be used when a question arises of a currently-privileged provider's ability to provide safe, high quality patient care. The FPPE occurs for a limited time period during which the Medical Staff evaluates the provider's professional performance. There are two types of FPPE: Proctoring FPPE and Secondary FPPE. [

B. Proctoring, which is outlined in Section 5.6 above, is Initial FPPE. Proctoring FPPE is required for all new privileges and standardized procedures. This includes privileges and standardized procedures requested by new applicants and all newly-requested privileges and standardized procedures for existing providers. There is no exemption based on board certification, documented experience, or reputation. A Provisional Medical Staff Member or Affiliated Professional who is undergoing Proctoring FPPE will remain in provisional status until the Proctoring FPPE is completed successfully.

C. Secondary FPPE, the second type of FPPE, is required when an issue regarding patient care or any other clinical or practice concern by a Practitioner is identified and requires more than a verbal warning but does not rise to the level of a corrective action investigation.

D. The outcome of each type of FPPE must be documented as outlined in subsection 5.6.1 above.

E. In addition, Secondary FPPE will always include a written summary submitted to the Credentials Committee at the time the issue is identified and the Secondary FPPE period begins. This written summary will include: the issue identified; a description of the counseling and/or training used; the method of monitoring; a target date for closure; and a final outcome/metric to be achieved for successful completion of the Secondary FPPE. At the target date for closure the assigned Proctor will submit a report to the Credentials Committee to determine closure or the need for continued monitoring. The Credentials Committee has sole power to determine whether the Secondary FPPE has been successfully completed, to extend the Secondary FPPE, or to recommend other appropriate action. Other Corrective Action may be initiated as otherwise outlined in this Article 6.

F. Although Initial and Secondary FPPE are focused on education and improvement, any issues addressed during either type of FPPE, including but not limited to recurring issues and the failure to successfully complete Secondary FPPE, can be considered progressive steps in the Medical Staff's efforts to address performance, clinical quality, professionalism, and other issues. Information obtained from the FPPE process may also be shared with the Quality Management Department for process improvement purposes while maintaining confidentiality of the information. Such information may also be shared with UCSF (for UCSF employees) or City Human Resources (for City employees), as appropriate, when a problem warrants a separate investigation for potential discipline.

6.1.3. Ongoing Professional Practice Evaluation (Maintaining Privileges)

A. The Ongoing Professional Practice Evaluation (OPPE) is a process required by the Joint Commission regarding maintaining privileges of the Medical Staff at the Hospital and serves as an ongoing monitoring system for competence and professionalism of individual Medical Staff Members and Affiliated Professionals (Practitioners). Each Practitioner will be reviewed in their respective department on a periodic basis. Per the Joint Commission, this process involves identification of professional practice trends that impact quality of care and patient safety, and such identification may require intervention

by the Medical Staff. The Joint Commission standard lists criteria that may be considered during the OPPE and possible sources of information

B. The OPPE process occurs on the schedule maintained by the Credentials Committee in coordination with the MSSD. The OPPE process will always include a written summary submitted by the department to the Credentials Committee to include: the OPPE plan for the department; a description of the metrics selected by the department for the review; the method of monitoring; and a final outcome/metric to be achieved for successful completion of the OPPE. At the target date for closure the department will submit a report to the Credentials Committee regarding the outcome of the review. The Credentials Committee has sole power to determine whether the OPPE has been successfully completed, to extend the OPPE, or to recommend other appropriate action regarding any Practitioner who fails to show appropriate competencies. Moreover, two consecutive unsatisfactory or three consecutive marginal ratings in any metric will always require the department to initiate an FPPE.

C. Information obtained from the OPPE process may be shared with the Quality Management Department for process improvement purposes while maintaining confidentiality of the information.

D. If there is uncertainty regarding the Practioner's professional performance, the Medical Staff should refer the issue for further evaluation of the Practitioner under these Bylaws.

6.2. **Professional Standards of Behavior**

6.2.1. Professional Conduct

The Chiefs of Clinical Services are responsible for monitoring the professional behavior of Practitioners of their service and addressing inappropriate behaviors as described in the Hospital institution-wide Code of Professional Conduct Policy.

Expected behaviors of Members of the Medical Staff and Affiliated Professionals:

A. All Members and Affiliated Professionals are expected to practice with professionalism and respect towards patients, colleagues, and others, including ensuring a high quality of services rendered and that care meets professional expectations. All Practitioners are expected to maintain professional communication and confidentiality, and to promptly address improvement expectations communicated through Medical Staff, human resources, or other avenues.

B. Examples of inappropriate behaviors include, but are not limited to, the following:

1) Shouting or using vituperative language;
2) Use of profanity directed at an individual;
3) Slamming or throwing objects;
4) Physical or verbal intimidation, harassment and/or violence;
5) Hostile, condemning, or demeaning communications;
6) Derisive, insulting, or demeaning criticism of performance;

7) Deliberate failure to abide by Hospital, Medical Staff, departmental or committee bylaws, policies and procedures, or directives, including but not limited to, refusal to comply with required duties;

8) Behavior inappropriate to the delivery of quality patient care; and

9) Retaliation against any person who addresses or reports incidents of unacceptable behavior.

Expressing contrary opinions is not disruptive conduct, nor is expressing concern regarding constructive criticism of existing policies or procedures or questioning potentially unacceptable performance or conditions, if it is done in good faith, in an appropriate time, place and manner, and with the aim of improving the environment of care rather than personally attacking any individual.

6.2.2. Investigation in Response to Alleged Inappropriate Behavior

A. Alleged violations of these Bylaws, other relevant policies, or the Code of Professional Conduct may be reported by any Hospital personnel using the confidential and Evidence Code §1157-protected Safety And Feedback Events (SAFE) reporting form maintained by the Quality Management Department and designed for this purpose, or reported in writing to a direct supervisor, the Chief of Service, or the Chief of Staff. Confidentiality will be maintained throughout the investigation of the alleged behavior and for any counseling, warning, or disciplinary action resulting from the investigation. The Chief of Service or designee will inform the person allegedly demonstrating inappropriate behavior of the report, and that person will have the opportunity to respond to or refute the allegations. If the investigation finds that the allegation does not meet the level of inappropriate behavior in violation of these Bylaws, applicable policies, or the Code of Professional Conduct, the report will be closed and dismissed. Dismissed reports will not be considered in determinations of recurrent inappropriate behaviors.

B. The Chief of Service will conduct an initial investigation within one (1) week of becoming aware of the issue. When the Chief of Service is the subject of the alleged behavior, the Chief of Staff will conduct the investigation. The Chief of Service may discuss the event with the affected Member or Affiliated Professional. The Chief of Service or Chief of Staff will take appropriate action based on the following guidelines:

1) Dismissed/No Action: The alleged behavior does not meet the level of inappropriate behavior in violation of these Bylaws, applicable policies, or the Code of Professional Conduct. The Chief of Service will report this outcome to Risk Management, including a brief explanation of why the alleged behavior did not meet the level of inappropriate behavior. The UO report will be recorded as "dismissed." No further action will be taken.

2) Meeting for Resolution: The behavior is relatively minor, had low potential to adversely affect patient care, and likely can be resolved by a meeting of the

involved parties. The Chief of Service may convene and facilitate a face-to-face meeting for resolution between the Member or Affiliated Professional (Practitioner) and the affected party. The Chief of Staff may help identify an alternative facilitator/mediator upon request. The Chief of Service will notify Risk Management of the outcome of the Meeting for Resolution.

3) Verbal Counseling: The behavior had the potential to adversely affect patient care and is a first confirmed inappropriate behavior event for the Practitioner. The Chief of Service will verbally counsel the Practitioner when an instance of inappropriate behavior warrants such counseling. The verbal counseling will emphasize the particular conduct that is inappropriate and stress that future similar conduct may result in more formal action under the Corrective Action procedures or as allowed by these Bylaws. The Chief of Service will create a written record of the verbal counseling, including the expectations, action plan, and consequences of repeat behavior of a similar nature (which will include written counseling) communicated to the Practitioner. A Practitioner also may be directed by the Chief of Service to issue an apology to the involved party or parties. The Chief of Service will maintain documentation of the counseling and notify Risk Management of this outcome.

4) Written Counseling: The behavior had the potential to adversely affect patient care and is sufficiently serious to make verbal counseling insufficient or inappropriate, or it represents recurrent inappropriate behavior that previously was addressed with verbal counseling. The Chief of Service will meet with the Practitioner and write a formal letter that sets forth the serious nature of the inappropriate behavior, reiterates any previous verbal counseling in relation to similar inappropriate behavior exhibited by the Practitioner, emphasizes the responsibility of Practitioners to treat all persons at the Hospital courteously, respectfully, and with dignity, and informs the Practitioner that future similar conduct may result in referral of the matter to the MEC for possible Corrective Action. The letter will include expectations, the action plan, and the consequences of repeat behavior of a similar nature. The Chief of Service may also direct the Practitioner to issue an apology to the involved party or parties. The Chief of Service will send a copy of the written counseling to the Chief of Staff, the Vice Dean, and the MSSD for inclusion in the Practitioner's peer review (credentials) file. The Practitioner may submit a letter of rebuttal that will be placed in the Practitioner's peer review file. The Chief of Service will report this outcome to Hospital and UCSF ZSFG Risk Management.

5) Action Plans may include remedial education, referral for psychological evaluation and treatment, referral for anger management counseling, or other professional assistance programs. The Chief of Service is encouraged to consult with the Chief of Staff, Vice Dean, Chief Medical Officer and/or Chief Executive Officer in determining the appropriate plan of action. The Chief of Service, in consultation with the Chief of Staff, Vice Dean, Chief Medical Officer and/or Chief Executive Officer as appropriate, may revise the level of action after further information is obtained in the course of investigation and counseling.

6) Reporting: The Chief of Staff will report aggregate data on Code of Professional Conduct issues to the MEC no less than annually. The identity of individual Practitioners will not be disclosed in these reports.

7) Progressive Discipline: While, in general, progressive corrective action interventions are appropriate, there is no prescribed number or order of corrective interventions to address remediation. The choice of corrective action intervention is left to the determination of the Chief of Service or Chief of Staff

6.2.3. Medical Executive Committee Approval is not Required and Procedural Rights are not Triggered

The approval of the MEC is not required for actions taken by the Chiefs of Service as set forth in Section 6.2 of these Bylaws, nor do such actions give rise to procedural rights for the Practitioner as set forth in Article 7 herein.

6.3. Corrective Action Investigations

6.3.1. Criteria for Initiation of Corrective Action

A corrective action investigation may be initiated whenever reliable information indicates that a Practitioner may have exhibited acts, demeanor, or conduct, either within or outside of the Hospital, that are reasonably likely to be any of the following:

C. Detrimental to patient safety or to the delivery of quality patient care within the Hospital;

D. Unethical;

E. Contrary to these Bylaws and/or the Medical Staff Rules and Regulations;

F. Below applicable professional standards;

G. Detrimental to Medical Staff or Hospital operations; and/or

H. Inappropriate behavior of sufficient seriousness or a documented pattern of inappropriate behavior as defined as more than two (2) incidents warranting verbal or written counseling within a two (2) year period or more than two (2) incidents .

6.3.2. Initiation of Corrective Action

A. Any person who believes that corrective action may be warranted may provide information to the Chief of Staff, any other Medical Staff officer, any Chief of Service, the Governing Body, or the Chief Executive Officer.

B. If the Chief of Staff, any other Medical Staff officer, any Chief of Service, the Governing Body, or the Chief Executive Officer determines that Corrective Action may be warranted under this Article 6. of these Bylaws, that person or entity may request the initiation of a formal Corrective Action Investigation or may recommend particular Corrective Action. Such requests must be conveyed to the MEC in writing. The MEC may conduct an informal review of the matter to determine whether an investigation is warranted.

C. The Chief of Staff will notify the Chief Executive Officer and the MEC and will continue to keep them fully informed of all action taken. In addition, the Chief of Staff will promptly forward all necessary information to the committee or person that will conduct any Investigation, as that term is defined in subsection 6.3.3.

6.3.3. Formal Investigation

A. If the MEC concludes that a formal investigation (an "Investigation") is warranted, it will direct an Investigation to be undertaken. The MEC may conduct the Investigation itself, may assign the Investigation to an officer of the Medical Staff or a standing committee of the Medical Staff, or may appoint an ad hoc committee to conduct the Investigation. The person or group conducting the Investigation is referred to as the "Investigator."

B. The affected Practitioner will be given an opportunity for an interview during the course of the Investigation to discuss or refute the charges or, in the discretion of the Investigator, to otherwise provide input regarding the Investigation. Such an interview does not constitute a "hearing" as the term is used in Article 7 of these Bylaws, and none of the procedural rights under Article 7 of these Bylaws will apply to the interview or the Investigation.

C. The Investigation will proceed in a prompt manner, and the Investigator must maintain a written record of its proceedings.

D. The Investigator must determine whether the Practitioner has provided a quality of care or professionalism that, in its unbiased and good faith determination, is consistent with the expectations for Practitioners.

E. The Investigator must forward a written report of the Investigation to the MEC within fifteen (15) days of completion of the Investigation. The report must include findings of fact and recommendations for appropriate corrective action, if any. The deadline for submission of the written report may be extended by the MEC for good cause.

F. If the MEC concludes action is indicated, but no further Investigation is necessary, it must proceed to take action.

6.4. Corrective Action

6.4.1. Medical Executive Committee Action

Within fifteen (15) days of receipt of the written report of the Investigation, the MEC will take action that may include, without limitation:

A. Determining that additional information is needed, in which case MEC will direct how that information will be obtained for consideration by the Investigator or MEC.

B. Determining no corrective action be taken. If the MEC determines there was no credible evidence for the complaint, any adverse information included in the complaint must be removed from the Practitioner's credentials file.

C. Deferring action for a reasonable time when circumstances warrant.

D. Issuing letters of admonition, censure, reprimand, or warning, although nothing herein precludes department or committee chairs from issuing informal written or oral warnings outside of the mechanism for Corrective Action. In the event such letters are issued, the

affected Practitioner may provide a written response that will be placed in the Practitioner's file.

E. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff Practitionership or exercise of Clinical Privileges or Standardized Procedures, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring. *

F. Recommending reduction, modification, suspension or revocation of Clinical Privileges or Affiliate Status. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended must be stated. *

G. Recommending suspension, revocation or probation of Medical Staff membership or affiliation (i.e. revocation of Clinical Privileges or Affiliate Status, or limiting Standardized Procedures). If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended must be stated. *

H. Taking other actions deemed appropriate under the circumstances.

** Actions reported to the Practitioner's professional licensing organization (such as the Medical Board of California) and entered into the National Provider Data Bank.*

The date for taking action may be extended by the MEC for good cause.

6.4.2. Procedural Rights

A. When No Corrective Action is Required or a Letter is Issued or Non-Reportable Action is Taken

If the MEC determines that no corrective action is required, that only a letter of warning, admonition, reprimand, or censure should be issued, or that other action is to be taken that is not reportable to the Member or Affiliated Professional's professional licensing organization, the decision will be transmitted to the Governing Body. The Governing Body may affirm, reject, or modify the action. The Governing Body must give great weight to the MEC's decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the MEC, and the MEC still has not acted. The decision becomes final if the Governing Body affirms it or takes no action on it within seventy (70) days after receiving the Notice of Decision.

B. When Corrective Action Requiring a Hearing is Recommended

If the MEC recommends an action that is a ground for a hearing under Section 7.2 of these Bylaws, the Chief of Staff will give the Practitioner Notice of the adverse recommendations and of the right to request a hearing in accordance with Section 7.3 of these Bylaws. In the case of Members of the Medical Staff, the Governing Body may be informed of the recommendation, but will take no action until the Member has either waived the Member's right to a hearing or completed the hearing. Affiliated Professionals do not have the right to request a hearing per these Bylaws Section 4.7.5.

6.4.3. Initiation of Governing Body Action

If the MEC fails to investigate or take corrective action, contrary to the weight of the evidence, the Governing Body may direct the MEC to initiate investigation or corrective action for any Member or Affiliated Professional, but only after written notice to the MEC. If the MEC fails to take action in response to the Governing Body's direction, the Governing Body may initiate investigation and corrective action, but this corrective action must comply with these Bylaws. The Governing Body must inform the MEC in writing of such action.

6.4.4. Other Action

Nothing in this Article 6 or elsewhere in these Bylaws is intended to limit the University's or City's ability to take appropriate action with respect to employment. The University and the City have their own processes for employee discipline or other issues that are separate and distinct from processes under these Bylaws. To the extent that the University or City take action against their own employees through their respective processes, such processes include appropriate due process protections.

6.5. Summary Action

6.5.1. Criteria for Initiation

A. Whenever the Member's or Affiliated Professional's conduct is such that a failure to take action may result in imminent danger to the health or safety of any individual, the Chief of Staff, the MEC, or the Chief of Service in which the Practitioner holds Privileges may summarily restrict or suspend the Medical Staff membership, Clinical Privileges, or Affiliate Status of such Practitioner.

B. Unless otherwise stated, such summary restriction or suspension ("Summary Action") becomes effective immediately upon imposition, and the person or body responsible will promptly give written notice generally describing the reasons for the action to the Practitioner, and notice to the MEC, the Chief Executive Officer, and the Governing Body.

C. The Summary Action may be limited in duration and will remain in effect for the stated period or until resolved as set forth in these Bylaws. Unless otherwise indicated by the terms of the summary action, the Chief of the involved Clinical Service will make the necessary arrangements to provide alternate coverage for proper and necessary patient care during the period of restriction or suspension.

D. The notice of the Summary Action given to the MEC constitutes a request to initiate corrective action, and the procedures set forth in Article 6 of these Bylaws must be followed.

6.5.2. Medical Executive Committee Action

The affected Member may request an interview with the MEC. The interview must be convened as soon as reasonably practicable under the circumstances but in no event less than seven (7) days after the Summary Action was taken. The interview does not constitute a hearing, as that term is used in these Bylaws, and none of the procedural rights under Article 7 of these Bylaws apply to Summary Actions. The MEC may thereafter continue, modify, or terminate the terms of the Summary Action. It will give the Member written Notice of its decision, which must include the information specified in Section 7.3 of these Bylaws if the action constitutes grounds for a hearing.

6.5.3. Procedural Rights

Unless the MEC terminates the Summary Action, it remains in effect during the completion of the corrective action and hearing and appellate review process. When a Summary Action is continued, the affected Member is entitled to the procedural rights set forth in Article 7 these Bylaws, but the hearing may be consolidated with the hearing on any corrective action that is recommended so long as the hearing commences within forty (40) days after the hearing on the Summary Action was requested.

6.5.4. Initiation of Corrective Action by the Governing Body

A. If no one authorized under Section 6.5 of these Bylaws is available to take a Summary Action to summarily restrict or suspend a Member's or Affiliated Professional's membership, Privileges, or Affiliate Status, the Governing Body (or its designee) may immediately suspend or restrict a Practitioner's Privileges if failure to do so may result in imminent danger to the health or safety of any individual, provided that the Governing Body (or its designee) has made reasonable attempts to contact the Chief of Staff, the MEC, and the Chief of the Service to which the Member is assigned before acting.

B. Such Summary Action imposed under this subsection 6.5.4 is subject to ratification by the MEC. If the MEC does not ratify such Summary Action within two (2) working days of its imposition, excluding weekends and holidays, the Summary Action will terminate automatically.

6.5.5. Reporting

When Summary Action involves summary suspension of privileges, membership, or affiliate status, the Summary Action must be reported under Section 805 of the Business and Professions Code if such Summary Action remains in effect for a period in excess of fourteen (14) days.

6.6. Administrative Suspension of Privileges

6.6.1. Basis for Administrative Suspensions

The Chief of Staff may administratively suspend a Practitioner's Privileges or Affiliate Status for failing to complete training mandated by the hospital for regulatory purposes, failing to complete medical record documentation on a timely basis, failing to complete administrative responsibilities as required by the Chief of Service or Chief Executive Officer, and failure to obtain required health screening. Such administrative suspensions do not give rise to the due process rights of these Bylaws unless the suspension is in place for more that fourteen (14) days consecutively or thirty (30) days in a year and therefore becomes reportable to the Practitioner's professional licensing organization (such as the Medical Board).

6.6.2. Licensure

Automatic suspension or termination of Privileges or membership, or affiliate status may occur as described:

A. Whenever a Practitioner's license or other legal credential authorizing practice in this state is revoked, limited, suspended, or expires, the Practitioner's Medical Staff membership, Privileges, or Affiliate Status are automatically suspended as of the date such action or expiration becomes effective. Renewal of a Practitioner's license or other

legal credential authorizing practice is the sole responsibility of the Practitioner. Any notices of upcoming license renewal deadlines provided by the Hospital are a courtesy, and the failure of a Practitioner to receive or review such notices does not excuse a lapsed license or legal credential.

B. Whenever a Practitioner's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any Privileges or Affiliate Status that are within the scope of such limitation or restriction are automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

C. Whenever a Practitioner is placed on probation by the applicable licensing or certifying authority, the Practitioner's membership status and Privileges or Affiliate Status automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

D. Whenever a Practitioner's professional liability insurance required by subsection 2.2.4 lapses, the Practitioner's Medical Staff membership and Privileges or Affiliate Status are automatically suspended as of the date such lapse becomes effective shall remain suspended until adequate evidence of insurance is provided. If the Practitioner fails to provide adequate evidence of insurance within six (6) months, it is deemed as a voluntary resignation from the Medical Staff.

E. If the employment of a Practitioner who is a City employee is terminated or suspended by the City or the employee resigns, the Practitioner's Medical Staff membership and Privileges or Affiliate Status are automatically terminated or suspended, respectively, on the date such employment action becomes effective. If the employment or contractual relationship of a Practitioner who is a UCSF employee or contractor is terminated or suspended by UCSF or the contractor or the employee or contractor resigns, the Practitioner's Medical Staff membership and Privileges are automatically terminated or suspended, respectively, on the date such relationship change becomes effective. And if the employment or contractual relationship of a Practitioner who is a UCSF employee is transferred to another UCSF location or the Practitioner is removed by UCSF from providing patient care at the Hospital, the Practitioner's Medical Staff membership and Privileges or Affiliate Status are automatically suspended on the date such relationship change or reassignment becomes effective. This subsection E does not impose automatic suspension or termination on someone who either (i) moves employment between the City and UCSF if they are still assigned to provide patient care at the Hospital or (ii) shifts from being employed by the City or UCSF to being a volunteer at the Hospital. In either instance, the Practitioner's Medical Staff membership and Privileges or Affiliate Status may continue as allowed by these Bylaws so long as (a) the Practitioner is in good standing, (b) the Practitioner has professional liability insurance as required by subsection 2.2.4 above, and (c) the Chief of Staff approves the continuance.

F. A Practitioner's Privileges or Affiliate Status automatically suspended under this subsection 6.6.2 may be reinstated during the then-current term only upon written notice from the Chief of Staff or the Chief of Staff's designee and with consent of the Hospital Chief Executive Officer. Such reinstatement may include restrictions if imposed in accordance with Section 6.3. If the Practitioner provided patient care at the Hospital, or

any City-affiliated institution while the Practitioner's license or credential was revoked, suspended, expired, limited, or restricted or while the Practitioner was on probation, reinstatement may not be granted until all instances of the Practitioner's patient care and billing during that time are reviewed to ensure that appropriate care was rendered, and to prevent improper billing.

6.6.3. DEA Certificate

A. Whenever a Practitioner's DEA certificate is revoked, limited, suspended, or expires, the Practitioner is automatically and correspondingly divested of the right to prescribe or supervise prescription of medications covered by the certificate as of the date such action becomes effective throughout its term. The Practitioner must immediately notify the MSSD of any such revocation, limitation, suspension, or expiration.

B. Whenever a Practitioner's DEA certificate is subject to probation, the Practitioner's right to prescribe such medications is automatically subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

6.6.4. Medical Records

Practitioners are required to complete medical records within the time prescribed by the MEC. Failure to timely complete medical records results in an automatic suspension after notice is given. Such suspension applies to the Practitioner's right to admit, treat, or provide services to patients in the inpatient or outpatient settings. The suspension will continue until the Practitioner completes the records at issue and any related concerns are resolved.

6.6.5. Procedural Rights

Practitioners whose Privileges are automatically suspended and/or who have been deemed to have automatically resigned the Practitioner's Medical Staff membership are entitled to the procedural rights set forth in Article 7 of these Bylaws only if the suspension or resignation is reported pursuant to California Business and Professions Code Section 805.

6.6.6. Notice of Administrative Suspension and Transfer of Patients

Notice of an automatic suspension must be given to the Practitioner and to the appropriate Chief of Service, and patients affected by an automatic suspension will be assigned to another Practitioner of the Clinical Service.

6.6.7. Automatic Termination

If a Practitioner is administratively suspended for more than three (3) months, the Practitioner's membership or Affiliate Status is automatically terminated. Thereafter, reinstatement to the Medical Staff requires application and compliance with the appointment applicable to new Applicants.

ARTICLE 7. HEARINGS AND APPELLATE REVIEWS

7.1. **General Provisions**

Except as otherwise provided in these Bylaws, the following definitions and rules apply under this Article.

A. "Respondent" refers to the MEC in all cases when the MEC or authorized Medical Staff officers, Members, or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Governing Body in all cases where the Governing Body or its authorized officers, directors, or committees took the action or rendered the decision which resulted in a hearing being requested.

B. "Party" and "Parties" refer to the Petitioner and Respondent, individually (Party) or collectively (Parties).

C. "Petitioner" refers to the Member who requested a hearing pursuant to subsection 7.3.2 of these Bylaws.

D. Technical, insignificant, or non-prejudicial deviations from the procedures set forth in these Bylaws are not grounds for invalidating the action taken.

E. If an adverse action described in subsection 7.2.1 of these Bylaws is taken or recommended, the Petitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

7.2. **Hearings**

7.2.1. Grounds for Hearings

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions regarding a Member of the Medical Staff is deemed an actual or potential adverse action and constitutes grounds for a hearing:

A. Denial of Medical Staff appointment, reappointment, or Privileges;

B. Revocation, suspension, restriction, or involuntary reduction of Medical Staff membership and/or Privileges;

C. Involuntary imposition of significant consultation or proctoring outside of the FPPE process; or

D. Any other corrective action or recommendation that must be reported to the Member's professional licensing organization (such as the Medical Board) pursuant to California Business and Professions Code Section 805.

7.2.2. Termination from Medical Staff

Removal from a position as Chief of a Clinical Services or as an Officer of the Medical Staff, termination from the Medical Staff following two (2) years of inactive status, or termination from the Medical Staff following a resignation or lay off from employment with the University or the City, **does not** constitute grounds for a hearing.

7.2.3. Actions Taken Against Affiliated Professionals

Affiliated Professionals are subject to corrective action processes pursuant to their employer's policies and procedures or through other contractual arrangements. Notwithstanding

the foregoing, clinical privileges or standardized procedures exercised by Affiliated Professionals are subject to oversight by the Medical Staff. Any performance concerns or problems with clinical care related to Affiliated Professionals that are addressed by the Medical Staff, which will occur in consultation with the City Attorney's Office serving as counsel to the Medical Staff, may result in clinical privilege or Affiliate Status restriction, suspension, or termination by the Medical Staff, including pursuant to the following:

A. The Chief of Staff or the Chief of Staff's designee will determine how the issue is investigated. The Chief of Staff may appoint an *ad hoc committee* to investigate or advise the Chief of Staff and MEC. Any investigation should include an interview of the Affiliated Professional. Prior to the Medical Staff's restriction, suspension, or termination of Clinical Privileges or Affiliate Status of an Affiliated Professional, the affected Affiliated Professional will be given notice of the proposed action and afforded an opportunity to submit a written rebuttal to the Chief of Staff or the Chief of Staff's designee. The Chief of Staff or the Chief of Staff's designee in consultation with the MEC is authorized to make a recommendation on behalf of the Medical Staff and will do so in consultation with the City Attorney's Office. Notice of the decision will be given to the Affiliated Professional.

B. The Chief of Staff or Chief of Staff's designee will inform the Governing Body of any recommendation that involves the restriction or suspension of Clinical Privileges or Affiliate Status of an Affiliated Professional for a cumulative total of thirty (30) days or more in any twelve (12)-month period or termination of such privileges. Prior to informing the Governing Body of the recommended restriction, suspension, or termination of Clinical Privileges or Affiliate Status of an Affiliated Professional, the affected Affiliated Professional will be given notice of the proposed action and afforded an opportunity to submit a written rebuttal to the Governing Body. The subsequent decision of the Governing Body is final.

C. This subsection 7.2.3 does not afford an Affiliated Professional a right to a hearing under Sections 7.3 and 7.4 of these Bylaws.

7.3. Requests for Hearing

7.3.1. Notice of Proposed Action

The Medical Staff Member Petitioner must be notified in writing (by "Notice") of any recommendations that would constitute grounds for a hearing. The Notice must inform the Petitioner of the following:

A. What action has been proposed against the Petitioner;

B. Whether the action, if finally adopted, will be reported to the Member's professional licensing organization (such as the Medical Board) under California Business and Professions Code Section 805 and to the National Practitioner Data Bank;

C. The reasons for the proposed action;

D. That the Petitioner may request a hearing;

E. That a hearing must be requested within twenty (20) days; and

F. That the Petitioner has the hearing rights described in the Medical Staff Bylaws.

7.3.2. Request for Hearing; Waiver and Consideration of Waived Hearing by the Governing Body

The Petitioner has twenty (20) days following receipt of Notice of such recommendation to request a hearing. The hearing request must be in writing, must be communicated at minimum by electronic mail, and must be addressed to the Chief of Staff with a copy to the Chief Executive Officer. The Petitioner must state, in writing, the Petitioner's intentions with respect to attorney representation during the hearing process at the time the Petitioner sends the request for a hearing.

If the Petitioner does not request a hearing within the time and in the manner described, the Petitioner will be deemed to have waived any right to a hearing and accepted the recommendation involved. Such final recommendation, based on a waiver of the right to hearing, will be considered by the Governing Body for ratification within seventy (70) days. The Governing Body must consider such final recommendation, but the recommendation is not binding on the Governing Body, which will exercise its independent authority to render a final decision on the matter.

7.3.3. Hearings Prompted by Governing Body Action

If the hearing is based upon an adverse action by the Governing Body, the President of the Governing Body or the President's designee will fulfill the functions assigned in this Section to the Chief of Staff. In such instances, the term "recommendation" used in this Section 7.3 includes any action by the Governing Body.

7.3.4. Time and Place for Hearing

Upon receipt of a timely request for a hearing made by the Petitioner, the Chief of Staff will notify the Chief Executive Officer and the MEC, appoint a Judicial Review Committee, and schedule a hearing before the Judicial Review Committee. The Chief of Staff will give notice of the hearing within twenty (20) days after receipt of the request. The notice must state the time, place, and date of the hearing. The date of the commencement of the hearing will be within twenty (20) to forty (40) days from the date the Chief of Staff received the hearing request. The date of commencement for the hearing may be extended by the Chief of Staff for good cause in the Chief's sole discretion.

7.3.5. Notice of Charges

As part of, or together with, the notice of place, time, and date of the hearing, the Chief of Staff must state in writing the reasons for the recommendation, the acts or omissions with which the Petitioner is charged, and a list of the medical records in question, when applicable. The Petitioner must be provided with a summary of the rights to which the Petitioner is entitled at the hearing. A supplemental notice of charges may be issued at any time, provided the Petitioner is given sufficient time (at least seven days) to prepare.

7.3.6. Judicial Review Committee

The Chief of Staff will appoint a Judicial Review Committee composed of not fewer than three (3) Members of the Active Medical Staff (Active Members) who will gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact finder, initial decision-maker, or otherwise actively participated in the consideration of the matter

leading up to the recommendation. The Judicial Review Committee may have any number of members or alternates as determined by the Chief of Staff. The Chief of Staff will appoint one of these Active Members to serve as Chair. Knowledge of the matter involved does not preclude a Member from serving as a member of the Judicial Review Committee. In the event it is not possible to appoint all Judicial Review Committee members from the Active Medical Staff, the Chief of Staff may appoint any Member of the Medical Staff or other people affiliated with DPH. When feasible, the Judicial Review Committee will include at least one (1) Member who practices in the same specialty as a Petitioner and will include at least one (1) Member who is a UCSF employee and one (1) Member who is an SDPH employee. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Judicial Review Committee member becomes unavailable. Voir dire is expressly allowed, and it is to be conducted via written questions for the JRC members and the Hearing Officer. The parties will submit questions to the Hearing Officer, who will make a decision on which questions to allow. The Hearing Officer may include their own questions. The written answers to the voir dire questions will be submitted to both sides and to the Hearing Officer, and the Hearing Officer makes any final decision on challenges to participation

The proceedings and/or deliberations of the hearing will continue so long as three members of the Judicial Review Committee are present.

7.4. **The Hearing Procedure**

7.4.1. The Hearing Officer

The Chief of Staff will appoint a Hearing Officer to preside at the hearing. The Hearing Officer must be an attorney-at-law qualified to preside over a quasi-judicial hearing; however, an attorney regularly utilized by the Hospital for legal advice regarding its affairs and activities is not eligible to serve as Hearing Officer. The Hearing Officer must not be biased for or against any Party, must not gain any direct financial benefit from the outcome, and must not act as a prosecuting officer or as an advocate. The Hearing Officer must endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard, to assure that all participants present relevant oral and documentary evidence in an efficient and expeditious manner, and to maintain proper decorum. The Hearing Officer will determine the order of, or procedure for, presenting evidence and arguments during the hearing and has authority and discretion to make all rulings on questions that pertain to matters of law, procedure, or the admissibility of evidence that are raised prior to, during, or after the hearing, including deciding when evidence may not be introduced, granting continuances, ruling on disputed discovery requests, and ruling on challenges to Judicial Review Committee Members or the Hearing Officer serving as the Hearing Officer. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as may be warranted by the circumstances. The Hearing Officer will participate in the deliberations of the Judicial Review Committee and be a legal advisor to it, but the Hearing Officer does not have a vote on the Judicial Review Committee.

7.4.2. The Chairperson of the Judicial Review Committee

The Chief of Staff will appoint the chairperson for the Judicial Review Committee. The chairperson will serve as a liaison between the Hearing Officer and the Judicial Review

Committee. The chairperson will take votes on issues to be decided by the JRC. The vote can be done in person, via telephone, via email, or through other methods. Any decision by the JRC shall be reported to the parties in terms of the numbers voting for and against each decision or outcome

7.4.3. Hearing Logistics

The hearing may take place in person, by videoconference, or in hybrid format, at the discretion of the Judicial Review Committee in consultation with the Hearing Officer.

The Judicial Review Committee will decide how it wants to structure the hearing, such as how many days of hearing to provide, how long each session will be, when it will start and stop sessions, etc.

If any members of the Judicial Review Committee cannot attend a session, the Judicial Review Committee will decide whether to allow the session to be recorded by video and to have the absent Committee members then watch the video after the session.

The JRC will decide how it wants to structure the hearing, such as how many days of hearing to provide, how long each session will be, when it will start and stop sessions, etc.

If any members of the JRC cannot attend a session, the JRC will decide whether to allow the session to be recorded by video and to have the absent JRC members then watch the video after the session.

The JRC itself, and not the Hearing Officer, will decide how much time to allot to the hearing, providing each side at least five hours to present its case. It is solely within the JRC's discretion to allow for additional time. The JRC may place reasonable limits on the amount of testimony or argument it wants to allow, bearing in mind the fact that written evidence in most situations is deemed admitted.

The JRC should review all non-repetitive written evidence submitted prior to making its decision.

The JRC members may ask questions of witnesses directly, preferably saving their questions for a natural pause or break in the testimony.

For most witnesses, each side must examine the witness on all relevant topics when that witness is first called to testify (extending from session to session as appropriate). This is to minimize disruption to the witnesses called to testify. Only in extreme situations and for good cause will the Hearing Officer allow a witness to be recalled to testify after each side has had a chance to examine the witness.

The JRC has authority to limit or exclude testimony of any witness based on argument by a party that the testimony is not relevant or is unnecessary. Any JRC member may make such a motion on their own, and the JRC may vote on that motion as with any other argument.

The JRC is to meet alone with the Hearing Officer after it receives the written evidence, statement of the applicable legal standard, and written summaries of the case and before the hearing commences. During that meeting the JRC may discuss any questions or has or ideas about structuring or limiting the scope or structure of the hearing. This meeting is not to be transcribed, but the JRC, working with the Hearing Officer, will provide each side with the rules

it has adopted about how the matter will proceed and a written statement of any other limits it puts on the hearing process.

7.4.4. Representation

A. The Petitioner is entitled, at the Petitioner's own expense, to be represented at the hearing by an attorney-at-law or by a physician licensed to practice in the State of California. If the Petitioner is represented by legal counsel, the MEC may also be represented by legal counsel. The MEC may not be represented by legal counsel if the Petitioner is not so represented. If the Petitioner elects not to be represented by an attorney at the hearing, the MEC will appoint a representative from the Active Medical Staff to present the recommendation and supporting evidence and to examine witnesses. Notwithstanding the foregoing and regardless of whether the Petitioner elects to have attorney representation at the hearing, the Parties have the right to consult with legal counsel to prepare for a hearing or an appellate review.

B. When Petitioner is represented by legal counsel, the Judicial Review Committee will determine the role of legal counsel at the hearing. The Judicial Review Committee may eject any legal counsel whose activities at the hearing are, in the judgment of the Judicial Review Committee, disruptive to the proper conduct of the hearing proceedings.

C. The Hearing Officer has discretion to limit the role of attorneys to advising the attorney's clients rather than presenting the case.

7.4.5. Postponements and Extensions

Postponements and extensions of the time limits beyond those listed in these Bylaws may be requested by anyone, may be granted by the Hearing Officer on a showing of good cause, and will be granted upon mutual agreement of the Parties and the Judicial Review Committee.

7.4.6. Failure to Appear or Proceed

Failure without good cause of the Petitioner to personally attend and proceed at a hearing in an efficient and orderly manner constitutes voluntary acceptance of the recommendations involved, and such recommendations will be forwarded to the Governing Body immediately for adoption in that event.

7.4.7. Discovery

A. Pre-hearing Documentation Review Expectation

The Judicial Review Committee will be provided a summative report of the investigatory and disciplinary actions taken to date on the matter being considered. Specifically, these should include at a minimum, the following documents: the investigatory committee report including findings and recommendations that were submitted to MEC, the motion and final MEC recommendation to the Governing Body, and any statements submitted by the Medical Staff member /Petitioner in participation of the investigatory committee process or in response to MEC action.

The parties may submit a written summary of the case not to exceed 5 single-spaced pages 15 days prior to the hearing to the Hearing Officer and the JRC members. The written summary may reference information that party plans to show through evidence and testimony. But not more than 5 pages may be submitted (e.g., no exhibits or attachments).

No less than 15 days before the start of the hearing, the JRC is to be given the recommendation of MEC in its entirety. The JRC is to be advised that the MEC recommendation is just a recommendation and that the JRC is charged with making a final decision on the issue. If the Member submitted any written rebuttal or response to the MEC recommendation prior to requesting a hearing, that written rebuttal or response is also to be provided to the JRC in the same timeframe.

Written evidence (the exhibits for each side) is to be exchanged between the parties and submitted to the Hearing Officer and the JRC 15 days prior to the start of the hearing. Exhibits must be marked sequentially with letters for the Member requesting the hearing and numbers for MEC. Each page of the written evidence should be marked with sequential numbering (Bates numbering) with a different prefix identifying which side originally provide the record.

All documents that are kept in the ordinary course of business—including but not limited to medical records, policies, emails, reports, Medical Staff Office files, a person's Medical Staff credentialing and privileges file, OPPEs/FPPEs, any written reports or summaries of the investigation leading to the hearing, and human resources files—are automatically admitted into evidence for consideration by the JRC. If a party has an objection to consideration of such written evidence, the objection must be made in writing, must be specific to any document listing the reasons for the objection, and must be provided to the Hearing Officer at least 5 days prior to the hearing. The Hearing Officer will rule on any objections, bearing in mind that the rules of evidence do not apply to the hearing and that in most situations the proper way to challenge evidence is for a party to argue about the weight, if any, the JRC should assign to the evidence. Only extreme cases—such as submission of privileged, attorney-client protected information or submission of evidence that is demonstrably false from an assessment of the context—support a decision by the Hearing Officer sustaining an objection. If an objection to a document is upheld by the Hearing Officer, the document or the aspect of the document that was objected to, is not to be considered by the JRC. Each side has the right during the hearing to comment on whether exhibits are reliable and what weight to give each exhibit. For sake of clarity, time during the hearing should not be spent arguing objections based on the rules of evidence because the rules of evidence do not apply and because the JRC is sophisticated and can be reminded of its duty to make a judgement about what weight to give evidence.

B. Legal Standard

A proposed statement of the legal standard applicable to the hearing is to be submitted to the Hearing Officer 15 days prior to the start of the hearing. The Hearing Officer will then decide what statement of the legal standard applicable to the hearing will be provided to the JRC. The Hearing Officer may adopt any portion of the proposed written statements and/or may draft their own language. The statement of the legal standard must be provided to the JRC at least 5 days prior to the start of the hearing.

C. Rights of Inspection and Copying

The Petitioner may inspect and copy (at the Petitioner's own expense) any documentary information relevant to the charges that the Respondent has in its possession or under its control. The Respondent may inspect and copy (at its expense) any documentary information relevant to the charges that the Petitioner has in the Petitioner's possession or under the Petitioner's control. The request for discovery must be fulfilled as soon as practicable. Failure to comply with reasonable discovery requests at least twenty (20) days prior to the hearing is good cause for a continuance of the hearing. The Petitioner may not retain or possess unredacted medical records that contain any protected health information, and any unredacted records must be kept securely during the Hearing process. Petitioner must consult with the City Attorney's Office before accessing any patient medical record for purposes of preparing for the Hearing in order to ensure compliance with state and federal privacy rules.

D. Limits on Discovery

The Hearing Officer will rule on discovery disputes the Parties cannot resolve. Discovery may be denied when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either Party does not extend to confidential information referring solely to individually identifiable Members other than the Petitioner, nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information. Protected health information of any patient is generally not to be disclosed during discovery and may only be produced in redacted form. If the volume of materials makes redaction unfeasible, then the Judicial Review Committee must impose reasonable restrictions, in consultation with the City Attorney's Office, to ensure that protected health information is not removed from the Hospital or disclosed.

E. Ruling on Discovery Disputes

In ruling on discovery disputes, factors that the Hearing Officer may consider include, but are not limited to, the following:

1) Whether the information sought may be introduced to support or defend the charges;
2) Whether the information is "exculpatory" or "inculpatory" in nature;
3) The burden on the Party in possession of producing the requested information; and
4) What other discovery requests the Party has previously submitted resisted.

7.4.8. Objections to Introduction of Evidence Previously Not Produced for the Medical Staff

The Respondent may object to the introduction of evidence that was not provided during the appointment or reappointment process or investigation of other matter at issue in the hearing. The information will be barred from the hearing by the Hearing Officer unless the Petitioner can prove the Petitioner previously acted diligently with respect to providing evidence and could not have submitted the information at issue.

7.4.9. Pre-Hearing Document Exchange

At the request of either Party, the Parties must exchange copies of all documents that will be introduced at the hearing. The documents must be exchanged at least seven (7) days before commencement of the hearing. A failure to do so is good cause for a continuance.

7.4.10. Witness Lists

At the request of either Party, each Party must furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that Party at the hearing.

Nothing in the foregoing sentence precludes the testimony of additional witnesses whose possible participation was not reasonably anticipated. The Parties must notify each other as soon as a Party becomes aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least seven (7) days prior to the hearing date at which the witness is to appear constitutes good cause for a continuance.

7.4.11. Procedural Disputes

A. The Parties have a duty to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

B. The Parties are entitled to file motions as deemed necessary to give full effect to the rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the Judicial Review Committee. Such motions must be in writing and must specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving Party must deliver a copy of the motion to the opposing Party, who will have seven (7) days to submit a written response to the Hearing Officer, with a copy to the moving Party. The Hearing Officer will determine whether to allow oral argument on any such motions. The Hearing Officer's ruling on the motion must be in writing and will be provided to the Parties promptly. All motions, responses, and associated rulings must be entered into the hearing record by the Hearing Officer.

7.4.12. Record of Hearing

A court reporter shall be present to make a record of the hearing proceedings. The cost of a court reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the Party requesting it. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken on oath or affirmation.

7.4.13. Rights of the Parties

The Petitioner may ask the Judicial Review Committee Members and Hearing Officer questions, if reasonably relevant in the determination of the Hearing Officer, that are directly related to evaluating the impartiality of the Judicial Review Committee Members or the Hearing Officer. Challenges to the impartiality of any Judicial Review Committee Member will be ruled on by the Hearing Officer, and challenges to the impartiality of the Hearing Officer will be ruled on by the Chief of Staff in consultation with the City Attorney's Office. Both Parties may: call and examine witnesses for relevant testimony; introduce relevant exhibits or other documents;

cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues, and otherwise rebut evidence; receive all information made available to the Judicial Review Committee; and submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner. The Petitioner may be called by the Respondent or by the Judicial Review Committee and examined as if under cross-examination. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

7.4.14. Rules of Evidence

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence do not apply to a hearing conducted under this Article. The Hearing Officer will admit, subject to subsection 7.4.1 above, for consideration any evidence, including hearsay, the Hearing Officer determines is relevant to the determination of the issues presented during the Hearing.

7.4.15. Burdens of Presenting Evidence and Proof

A. At the hearing, the Respondent has the initial duty to present evidence for each case or issue in support of its recommendation. The Petitioner may present evidence in response.

B. If the Petitioner is challenging denial of an initial application for Medical Staff membership or privileges, the Petitioner bears the burden of persuading the Judicial Review Committee, by a preponderance of the evidence (meaning that something is more likely than not to be true, based on a review of all relevant information), that the Petitioner is qualified for membership and/or the denied or restricted Privileges.

C. In relation to other recommendations, the Respondent bears the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that Respondent's recommendation is reasonable and warranted.

7.4.16. Adjournment and Conclusion

The Hearing Officer may adjourn the hearing and reconvene it at the convenience of the participants without providing any specific form of notice. Upon conclusion of the presentation of oral and written evidence, the hearing is deemed closed. The Judicial Review Committee must then, outside of the presence of any person other than the Hearing Officer, conduct its deliberations and thereafter issue a written decision and accompanying report listing the basis for the decision (the "Decision") as set forth in subsection 7.4.16 below.

7.4.17. Voting

Each decision by the JRC, including the final decision on the merits of the hearing, is to be made by majority vote, which means half of the JRC plus one vote. (If there's a tie, then the status quo can be maintained. If that's on the final MEC recommendation, you should consider if that means the recommendation is rejected.)

7.4.18. Basis for Decision

The decision of the Judicial Review Committee must be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and testimony. The Judicial Review Committee must determine whether the

Member has provided a quality of care or professionalism that, in its unbiased and good faith determination, is consistent with the expectations for Members.

7.4.19. Decision of the Judicial Review Committee

Except as outlined below in this subsection, within twenty (20) days after final adjournment of the hearing, the Judicial Review Committee must issue the Decision. The date for issuing the Decision may be extended by the Judicial Review Committee for good cause. But if the Petitioner is currently under suspension, the time for the Decision will be twelve (12) days after final adjournment. Final adjournment is when the Judicial Review Committee has concluded its deliberations. A copy of the Decision must be sent to the Chief Executive Officer, the MEC, the Governing Body, the Petitioner, and the Petitioner's representative (if applicable). The Decision must contain the Judicial Review Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the Petitioner and the Respondent must be provided a written explanation of the procedure for appealing the Decision. The Decision of the Judicial Review Committee is considered final, subject only to such rights of appeal or Governing Body review as described in these Bylaws.

7.5. **Appeal**

7.5.1. Time for Appeal

Within twenty (20) days after receipt of the decision of the Judicial Review Committee, either the Petitioner or the Respondent may request an appellate review by the Governing Body. Said request must be delivered to the Chief of Staff in writing, in person or by certified mail, and must include a brief statement as to the reasons for appeal. If such appellate review is not requested within such period, both sides are deemed to have accepted the recommendation involved, and that recommendation then becomes, pending ratification by the Governing Body, final and effective immediately.

7.5.2. Grounds for Appeal

On appeal, the Governing Body may exercise its independent judgment in determining:

(1) whether there was substantial failure of the Judicial Review Committee to comply with the procedures required by these Bylaws so as to deny fair hearing, (2) whether the decision is reasonable and warranted, and/or (3) whether any bylaw, rule, or policy relied on by the Judicial Review Committee is unreasonably applied or interpreted.

7.5.3. Time, Place, and Notice

In the event of an appeal to the Governing Body, the Governing Body will within thirty (30) days after receipt of such notice of appeal, schedule and arrange for an appellate review. The Governing Body will provide notice of the time, place, and date of the appellate review. The date of the appellate review must be within sixty (60) days from the date of receipt of the request for the appellate review; however, when a request for appellate review comes from a Member who is under suspension, the review must be held as soon as practical, but not to exceed thirty (30) days from the date of receipt of the request. The time for appellate review may be extended by the President of the Governing Body for good cause.

7.5.4. Nature of Appellate Review

The proceedings of the Governing Body under Section 7.5 are in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the Governing Body may, at its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Judicial Review Committee hearing. Each Party shall have the right to present a written statement in support of the Party's position on appeal, to personally appear and make oral argument, and to be represented by an attorney. At the conclusion of oral argument, if allowed, the Governing Body may then, at a time convenient to itself, conduct deliberations outside the presence of the Parties and each Party's representatives. The Governing Body may affirm, modify, or reverse the decision of the Judicial Review Committee or, at its discretion, refer the matter for further review and recommendation.

7.5.5. Final Decision

Within thirty (30) days after the conclusion of the proceedings before the Governing Body (including both the appellate hearing and subsequent deliberations), the Governing Body must render a final decision in writing and deliver copies of that decision to the Applicant or Member of the Medical Staff and to the Chief of Staff, in person or by certified mail.

7.5.6. Delegation to Governing Body Members on the Joint Conference Committee

Nothing herein prevents the Governing Body from delegating the appellate process to those Governing Body Members appointed to the Joint Conference Committee. In such an event, the Governing Body Members of the Joint Conference Committee must submit a written report and recommendations to the full Governing Body for approval.

7.5.7. Further Review

Unless the Governing Body refers the matter back to the Judicial Review Committee for further review and recommendations, the final decision of the Governing Body following the appeal procedures set forth in these Bylaws will be effective immediately and is not subject to further review. If the matter is referred back to the Judicial Review Committee for further review and recommendations, the Judicial Review Committee will promptly conduct its review and make its recommendations to the Governing Body. This further review process and the report back to the Governing Body must not exceed thirty (30) days except as the Parties may otherwise stipulate.

7.5.8. Right to One Hearing Only

Except as otherwise provided in these Bylaws, no Applicant or Member is entitled to more than one (1) evidentiary hearing and one (1) appellate review hearing on any matter which is the subject of an adverse recommendation.

7.5.9. Affiliated Professionals, House Staff, Medical Students, and Trainees

Affiliated Professionals, House Staff, Medical Students, and Trainees are not entitled to the procedural rights set forth in these Bylaws except as expressly listed in subsection 7.2.3 for Affiliated Professionals.

7.5.10. Denial of Applications for Failure to Meet the Minimum Qualifications

Applicants are not entitled to the procedural rights of these Bylaws if the Applicant's membership, Privileges, applications, or requests are denied because of the Applicant's failure: to have a current California license to practice medicine, dentistry, clinical psychology, or podiatry; to maintain an unrestricted DEA certificate (when it is required under these Bylaws); to maintain professional liability insurance (as required by the Bylaws); to meet any of the other basic standards specified in Article 2 of the Bylaws; or to file a complete application.

7.5.11. Automatic Suspension or Limitation of Privileges

A Member or Affiliated Professional is not entitled to any procedural rights when the Practitioner's license or legal credential to practice has been revoked or suspended as set forth in Article 6 of these Bylaws. In other cases described in Article 6 of these Bylaws, the issues which may be considered at a hearing, if requested, may not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the Member may continue to practice in the Hospital with those limitations imposed. Members whose Privileges are automatically suspended and/or who have resigned the Member's Medical Staff membership for failing to complete medical records or for failing to maintain malpractice insurance are not entitled under these Bylaws to any procedural rights, except when a suspension for failure to complete medical records will exceed fourteen (14) days and must be reported to the Member's professional licensing organization (such as the Medical Board) pursuant to California Business and Professions Code Section 805.

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ARTICLE 8. STRUCTURE OF THE MEDICAL STAFF

8.1. Medical Staff Year

The Medical Staff Year is July 1 through June 30.

8.2. Officers of the Medical Staff

The officers of the Medical Staff are the Chief of Staff, Chief of Staff-Elect, or, in alternate years, the Chief of Staff-Past.

8.2.1. Qualifications of Officers

Officers must be Members of the Active Medical Staff at the time of nomination and election and must remain Members in good standing during the Member's term of office.

8.2.2. Election of Chief of Staff-Elect

The Chief of Staff-Elect of the MEC will be elected at the Annual Meeting of the Medical Staff in alternate years for a one (1) year term unless a vacancy as described in this Article indicates a need to have an additional election to fill the positions.

The Nominating Committee must present a candidate to the Active Medical Staff Members in attendance at the Annual Meeting of the Medical Staff. Other nominations may be taken from the floor, with the approval of the nominee, prior to the meeting.

If floor nominations are made, a hand vote will be taken to elect the Chief of Staff-Elect. A simple majority of the Active Medical Staff Members attending the meeting will determine the election. If no floor nominations are made, a vote of acclamation will be requested by the presiding Chief of Staff.

8.2.3. Term of Office

The Chief of Staff will serve a two (2) year term of office. The Chief of Staff-Elect will serve a one (1) year term from the beginning of the Medical Staff year and assume the responsibilities of the Chief of Staff at the end of that term. Upon completion of the two (2) year term as the Chief of Staff, the outgoing Chief of Staff will serve one (1) year as Chief of Staff-Past and be available to serve as Acting Chief of Staff in the first year of the Chief of Staff's two-year term. The Chief of Staff-Elect will be available to serve as Acting Chief of Staff in the second year of the Chief of Staff's two-year term. The standard term of office for the Chief of Staff is two (2) years. When the Nominating Committee believes continuity should be prioritized due to particular circumstances, the Chief of Staff may be re-elected to serve one (1) additional year. In the event that the Chief of Staff is re-elected, then the Chief of Staff Past will continue as an officer of the Medical Staff.

8.2.4. Vacancies in Office

In the event of the temporary absence of the Chief of Staff, the Chief of Staff must designate a Member of the MEC or a previous Chief of Staff to serve as the acting Chief of Staff, including chairing the MEC meetings.

If the position of the Chief of Staff becomes permanently vacant during the first year of the two (2) year term, the Chief of Staff-Past will assume all designated responsibilities through the end of the Medical Staff Year. If the Chief of Staff-Past is unable to serve, the MEC will appoint an Acting Chief of Staff who will serve through the end of the Medical Staff Year. If the vacancy occurs in the second year of the Chief of Staff's elected term, the Chief of Staff-Elect will assume the duties of the office through the end of the Medical Staff Year and then continue as the Chief of Staff for a two (2) year term.

8.2.5. Duties of Officers

A. Chief of Staff

The Chief of Staff will:

1) Serve as Chief of the Medical Staff;
2) Represent the views, policies (including strategic planning and budget considerations), needs and grievances of the Medical Staff and MEC to the Governing Body, to the Chief Executive Officer, and to the Vice Dean;
3) Receive and present to the MEC the activities of the Governing Body;
4) Report Medical Staff activities to the Governing Body;
5) Be the spokesperson for the Medical Staff and the MEC in external professional and public relations;
6) Appoint committee Chairs and approve Members to all Medical Staff committees except the MEC and Joint Conference Committee;
7) Call, preside at, and be responsible for the agenda of all regular and special meetings of the MEC and of the Medical Staff;
8) Be responsible for the enforcement of Medical Staff Bylaws and for corrective action as provided for in these Bylaws;
9) In the interim between MEC meetings, performing those responsibilities of the MEC that, in their reasonable opinion, must be accomplished prior to the next regular or special meeting of the MEC;
10) Serve as a Member of the Joint Conference Committee;
11) Serve as a Member of the Credentials Committee;
12) Preside at the Annual Meeting of the Medical Staff;
13) Serve as an interface between the Medical Staff and the leadership of the hospital; and
14) Attend any Medical Staff committee meetings as necessary and appropriate in the Chief of Staff's discretion.

B. Chief of Staff-Elect

The Chief of Staff-Elect will:

1) Perform duties as assigned by the Chief of Staff and, in the absence of the Chief of Staff, assume the duties and have the authority of the Chief of Staff.

2) Serve as Chair of the Bylaws Committee, or co-chair the committee with the Chief of Staff;

3) Serve as a member of the Credentials Committee;

4) Serve on the MEC;

5) Beginning six (6) months prior to assuming the role of Chief of Staff, serve as a member of the Joint Conference Committee; and

6) Assume the office of Chief of Staff at the end of the current Chief of Staff's term.

C. Chief of Staff-Past

The Chief of Staff-Past will:

1) Perform duties as assigned by the Chief of Staff and assume the duties and have the authority of the Chief of Staff in the absence of the Chief of Staff;

2) Chair the Nominating Committee of the Medical Staff;

3) Serve on the MEC, Joint Conference Committee and the Credentials Committee.

8.2.6. Removal of Officers

A Medical Staff Officer may be removed from office for any valid cause including, but not limited to, failure to carry out the duties of the office, gross neglect or malfeasance in office, or serious acts of moral turpitude. Except as otherwise provided in these Bylaws, removal of Medical Staff officers may be initiated by the MEC or upon the written request of twenty percent (20%) of the Active Medical Staff. Such removal may be effected by majority vote of the MEC Members or by a two-thirds vote of the Active Medical Staff. Voting on the removal of an elected officer will be by secret written ballot.

ARTICLE 9. CLINICAL SERVICES

9.1. **Organization of Clinical Services**

9.1.1. Overall Supervision

Each Clinical Service will have a Chief who is responsible for the overall supervision of the clinical work, teaching, and research within that Clinical Service. Each Clinical Service may be organized into subsections.

9.1.2. Clinical Services

The Clinical Services are as follows: Anatomic Pathology, Anesthesiology and Peri-Operative Care, Community Primary Care, Oral & Maxillofacial Surgery, Dermatology, Emergency Medicine, Family and Community Medicine, Laboratory Medicine, Internal Medicine, Neurology, Neurosurgery, Obstetrics-Gynecology, Ophthalmology, Orthopedic Surgery, Otolaryngology and Head & Neck Surgery, Pediatrics, Psychiatry, Radiology, Surgery, and Urology.

9.2. **Qualifications, Selection and Tenure of Chiefs of Services**

9.2.1. Qualifications

A. All Chiefs of Service must be board certified or re-certified in their respective specialty.

B. Chiefs of Service must have a University faculty appointment, excepting the Chief of the Community Primary Care Service (CPC).

C. Chiefs of Service may be the Chair or Vice Chair of the Chief's respective University department.

D. Chiefs of Service must be Members of the Active Medical Staff, and Clinical Privileges will be determined as set forth in Article 6 of these Bylaws.

9.2.2. Selection of a Chief of Service

A. Upon notification that a Chief of Service will vacate the Chief of Service's position prior to the appointment of a new Chief of Service, the UCSF Department Chair and Vice Dean, in consultation with the Chief Executive Officer and Chief of Staff, will select a proposed Interim Chief of Service. After approval by MEC, the Chief of Staff will appoint the selected individual as the Interim Chief of Service.

B. Within six months of a vacancy for a Chief of Service, the Chief of Staff, in consultation with the Vice Dean, UCSF Department Chair and Chief Executive Officer, will appoint a search committee for a new Chief of Service. The search committee will be chaired by a Member of the Active Medical Staff and be composed of Members of the Active Medical Staff, University faculty, the Vice Dean or their designee, and the Hospital Chief Executive Officer or their designee. If the Department has clinically active Affiliated Professionals, at least one Affiliated Professional member of the Department will also be invited to join the search committee. The composition of the search committee will be approved by the University's Academic Affairs Office.

C. The Chief of Staff must consult with the Director of Health or designee, and the Chief Executive Officer, in appointing the ad hoc search committee for the selection of the Chief of Community Primary Care (CPC). The search committee for the Chief of CPC must be chaired by a Member of the Active Medical Staff and must include Members of the Active Medical Staff, Members of the CPC, the Director of Health or their designee, and the Chief Executive Officer or their designee, and at least one Affiliated Professional member of CPC.

D. The recommendations of the Chief of Service search committee will be made to the Chief of Staff and UCSF Department Chair who will, in consultation with the Vice Dean and Chief Executive Officer, nominate the new Chief of Service for that service. The recommendations of the search committee for the Chief of CPC will be made to the Chief of Staff who will, with the approval of the Director of Health, nominate the Chief of CPC.

E. Following recommendation of the Chief of Service candidate to the Chief of Staff and UCSF Department Chair, the UCSF Department Chair will conditionally offer the position to the Chief of Service Candidate and, in consultation with the Vice Dean, negotiate terms of the contract and support.

F. Once the candidate for Chief of Service has accepted the conditional offer, the Chief of Staff will proceed with facilitating the formal nomination process. The Chief of Service nomination will be acted upon by the MEC. Ratification of the nomination will be accomplished by a two-thirds vote and be forwarded to the Governing Body for approval.

G. Upon approval of the Governing Body of the new Chief of Service, the nominee will assume the office of Chief of Service for that service.

H. If the MEC or Governing Body disapprove the nomination, the Chief of Staff must reconstitute an ad hoc search committee.

9.2.3. Review and Reappointment

A. Chiefs of Clinical Services must be reviewed every five (5) years or at any time as requested by the Chief of Staff, the Vice Dean, or the Chief Executive Officer. Continuation as the Chief of Service is contingent upon a favorable result of this review.

B. The review will be led by the Vice Dean and Vice Dean's Office, and the results will be discussed with the Chief of Staff and the Chief Executive Officer.

C. A summary of the review will be placed in the Chief of Service's credentials file that includes strengths/accomplishments and areas for improvement.

D. The Chief of Staff, in consultation with the Vice Dean and Chief Executive Officer, will make a recommendation regarding the reappointment of a Chief of a Clinical Service based on the review committee's findings. The reappointment requires approval by a majority vote of the MEC and the Governing Body.

9.2.4. Removal of a Chief of Service

A. Request for removal of a Chief may be initiated by:

   1) A two-thirds vote that includes a combination of the Clinical Service's Active Medical Staff Members ;

   2) The Vice Dean, Chief Executive Officer, or Chief of Staff; or

   3) By two-thirds vote of the MEC.

B. When a request for removal has been initiated, a Review Committee will be appointed by the Chief of Staff in consultation with the Vice Dean, UCSF Department Chair and the Chief Executive Officer. The findings of the Review Committee must be acted upon by the MEC.

C. The recommendation of the MEC will be forwarded to the Governing Body for approval.

9.2.5. Temporary Absence of a Chief of Service

A. When a Chief of a Clinical Service is temporarily absent from the position for more than thirty (30) days, prompt notification must be made to the Chief of Staff. Upon receipt of such notice, the Chief of Staff will appoint an Acting Chief for the Clinical Service in consultation, when feasible, with the permanent Chief of Service, the UCSF Department Chair, the Vice Dean, and the Chief Executive Officer.

B. Appointment of an Acting Chief of a Clinical Service for more than ninety (90) days requires the approval of the MEC and the Governing Body.

9.3. Functions of a Chief of Service

Each Chief will:

9.3.1. Credentialing/Privileging

A. Recommend criteria for clinical privileges in the Clinical Service;

B. Recommend a sufficient number of qualified and competent individuals to provide care/clinical services;

C. Make reports to the Credentials Committee concerning the appointment, reappointment, and delineation of clinical privileges for each Applicant seeking privileges in the Clinical Service;

D. Make recommendations to the Credentials Committee regarding the qualifications and competence of Affiliated Professionals in the Clinical Service;

E. Make recommendations for granting temporary privileges; and

F. Be responsible for the evaluation of all new appointees and report thereon to the Credentials Committee.

9.3.2. Performance Improvement

A. Continuously monitor and evaluate the quality and appropriateness of patient care provided within the clinical service, including:

1) Recommend for approval by the Credentials Committee and MEC the criteria to be used in conduct of Ongoing Professional Practice Evaluation (OPPE) and conduct periodic OPPE for each Member and Affiliated Professional of the Clinical Service at an interval not to exceed twelve (12) months. Data used to complete OPPE forms will be maintained and stored in each Clinical Service for the duration of each medical staff Member's tenure, but in no event less than ten (10) years.

2) Monitor and evaluate the quality and appropriateness of patient care provided by the attending staff;

3) Monitor and evaluate the quality and appropriateness of House Staff supervision by attending staff; and

4) Monitor and evaluate the quality and appropriateness of patient care provided by House Staff.

B. Continuously monitor the professional performance of all individuals who have delineated clinical privileges or standardized procedures in the Clinical Service, and report thereon to the Credentials Committee as part of the reappointment process and at such other times as may be indicated;

C. Hold regular Performance Improvement Conferences no less than quarterly to present and discuss specific patient cases and best practices;

D. Appoint ad hoc committees and working groups as necessary to carry out quality improvement activities; and

E. Conduct a Focused Professional Practice Evaluation (FPPE) of any individual with privileges or standardized procedures in the Clinical Service if there is a reasonable basis to be concerned that the individual's professional qualifications, clinical ability, judgment, character, physical or mental health, professional ethics, or other matters might directly or indirectly affect patient care.

1) The FPPE must consider the individual's overall performance as well as specific cases. Comparison with historical, departmental, and external benchmarks may be considered.

2) A peer review panel may be appointed to conduct an FPPE.

3) Recommendations from an FPPE may be used as the basis for continued routine monitoring and education or for pursuing formal corrective action.

9.3.3. Education and Research

A. Be accountable to the Vice Dean and the UCSF Department Chairs for the conduct of graduate and undergraduate medical education and UCSF based research programs conducted in the Chief's Clinical Service; and

B. Be responsible for the establishment, implementation, and effectiveness of the orientation and supervision of the teaching, education, and research programs in the Clinical Service.

9.3.4. Administration

A. Designate an Acting Chief when unavailable for more than twenty (24) hours but less than thirty (30) days and communicate the designee to the Chief of Staff and Medical Staff Office. After thirty (30) days, the process described in subsection 9.2.5 must be followed.

B. Be responsible and accountable to the Governing Body, through the Chief of Staff, for all clinically and administratively related activities within the Clinical Service;

C. Be a Member of MEC and regularly disseminate decisions made and issues discussed at MEC meetings to the Members of the Clinic Service. It is the expectation that the Chiefs of the Clinical Services will attend at least fifty percent (50%) of the MEC meetings each year and that they will send a designee when unable to attend.

D. Be responsible for the integration of the Clinical Services into the primary functions of the organization;

E. Be responsible for the coordination and integration of interdepartmental and intradepartmental services;

F. Review and update the Clinical Service Rules and Regulations at least every two years;

G. Be responsible for the orientation of new Members and for the enforcement of the Medical Staff Bylaws and Rules and Regulations and the Hospital's policies and procedures within the respective Clinical Service;

H. Ensure adequate input from the Chief's Clinical Service at Medical Staff committee meetings through attendance by service Members;

I. Be responsible for implementation within the Clinical Service of actions taken by the Governing Body and the MEC;

J. Participate in the administration of the Chief's Clinical Service through cooperation with the Nursing Service, Hospital Administration, and all personnel involved in matters affecting patient care;

K. Report and make recommendations to Hospital Administration when necessary with respect to matters affecting patient care in the Clinical Service, including personnel, space, resources, supplies, special regulations, standing orders and techniques;

L. Be responsible for the process of assessing and recommending off-site sources that provide patient care services not available at the Hospital;

M. Assist in the preparation of annual records, including budgetary planning, pertaining to the Clinical Service as may be required by the Chief of Staff, the MEC, the Vice Dean, Chief Executive Officer, or the Governing Body;

N. Delegate to a vice chief or other Active Staff Member of the Clinical Service such duties as appropriate;

O. Establish divisions, sections, or services within the Clinical Service and appoint Chiefs thereof, subject to the approval of the MEC and the Governing Body;

P. Develop and implement policies and procedures that guide and support the provisions of services;

Q. Maintain quality improvement programs; and

R. Make a presentation to the MEC at least every two (2) years on the activities of the Clinical Service.

9.4. **Functions of Clinical Services**

S. Each Clinical Service must establish written criteria consistent with the policies of the MEC for the granting of Clinical Privileges and Standardized Procedures.

T. Each Clinical Service is responsible for maintaining and supervising a high quality education and training program for graduate and undergraduate education in the health sciences.

U. Each Clinical Service is responsible for the supervision of House Staff and the House Staff training programs.

V. The Chief of CPC will collaborate with the appropriate Chiefs of Clinical Services and the Vice Dean to maintain and supervise high quality training experiences within the CPC clinical sites for graduate and undergraduate students in the health sciences.

W. Each Clinical Service will develop criteria under which consultation will be required; these shall not preclude a requirement for consultation when the Chief of Service determines that a patient would benefit from such consultation.

X. Each Clinical Service will meet as frequently as necessary, but at least quarterly, to consider findings from the ongoing monitoring and evaluation of quality and appropriateness of the care and treatment provided to patients. Written summaries and recommendations of any and all new policies or changes in policies will be submitted to the Medical Executive Committee for its approval.

9.5. **Assignment to Clinical Service**

The MEC will, after consideration of recommendations of the Clinical Services as transmitted through the Credentials Committee, recommend initial Clinical Service assignments for all Applicants. All Medical and Affiliated Staff Members shall be assigned to at least one

Clinical Service and be granted clinical privileges or standardized procedures that are relevant to the care provided in that Clinical Service. The exercise of clinical privileges or standardized procedures within any Clinical Service are subject to the Medical Staff Bylaws, the Rules and Regulations of that Clinical Service, and the authority of the Chief of Service.

ARTICLE 10. MEDICAL STAFF AND AFFILIATE PROFSSIONALS LEADERSHIP

10.1. Definitions of Medical Staff and Affiliate Professional Leaders (in addition to Chiefs of Service as set forth in Article 9)

The term Medical Staff and Affiliate Professional Leaders includes the following positions:

A. **Central Leadership Positions:** (1) Medical Directors or Associate Chief Medical Officers of multi-specialty service lines or (2) Medical Directors of hospital departments that pertain to multiple services. (See Appendix 3.)

   Examples: 1. Medical Directors or Associate Chief Medical Officers of Critical Care, Perioperative Services, Trauma; 2. Medical Directors of Risk Management, Quality Improvement, Care Experience, Informatics, Infection Control.

B. **Service Leadership Positions:** Medical Directors or Vice Chiefs of units or services within a single Clinical Service.

   Examples: Medical Directors of Family Health Center, Medicine Inpatient Services, EMS Base Station, Sleep Center, Diabetes Program, Asthma Clinic.

10.2. Qualifications of Medical Staff and Affiliated Professional Leaders

Leaders must be Members of the Active Medical or Affiliated Staff at the time of appointment and must remain Members in good standing during the Member's tenure.

10.3. Appointment of Medical Staff and Affiliated Professional Leaders

A. Central leadership positions are appointed by an open search process organized by the Chief Medical Officer or designee. The search committee is composed of clinical stakeholder leaders. The candidate selected must be approved by the Chief Medical Officer, Chief Executive Officer, and Vice Dean.

B. Service Leadership positions are appointed by the Chief of Service.

10.4. Term of Appointment

A. Central leadership positions are one (1) year appointments subject to annual review based on satisfactory performance and the needs of the Hospital. Review is performed by the Chief Medical Officer in consultation with Executive Leadership.

B. Service Leadership positions are one (1) year appointments subject to annual review based on satisfactory performance and the needs of the Hospital. Review is performed by the Chief of Service in consultation with the Chief Medical Officer.

10.5. Reporting Relationships

A. Central leadership positions report to the Chief Medical Officer.

B. Service Leadership positions report jointly to their Chief of Service and Hospital Administration via the Chief Medical Officer for this administrative role.

10.6. **Duties of Medical Staff and Affiliated Professional Leaders**

A. In partnership with the Nurse dyad, the Leader is responsible for the quality of patient care, patient experience, and operational management of care provided by the clinical unit in alignment with True North goals and hospital leadership vision.

B. The central function of this position is to serve as the Leader for the clinical area, engaging front line providers to optimize operational, clinical quality, patient experience, and financial metrics. This includes meeting clinical enterprise performance and outcome benchmarks set by Hospital Administration.

C. Specific duties are detailed in the job descriptions.

10.7. **Salary Support for Medical Staff and Affiliated Professional Leader Effort**

A. Central leadership positions are funded via the Affiliation Agreement Central Medical Staff and Affiliated Professional Leadership account.

B. Service Leadership positions are funded by the Service.

ARTICLE 11. COMMITTEES OF THE MEDICAL STAFF

11.1. Committee Designation

Standing committees, subcommittees, and ad hoc committees of the Medical Staff described in these Bylaws and in the Committee Manual are created for and meet the purpose of peer evaluation and improvement of the quality of care rendered in the Hospital. Medical Staff functions covered by appropriate committees include, but are not limited to, executive review, credentialing, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting Medical and Affiliated Members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services.

11.2. General Provisions

11.2.1. Ad Hoc Committees

As the need arises, the Chief of Staff, with the advice and counsel of the MEC, may appoint ad hoc committees to deal with specific problems including the evaluation and improvement of the quality of care rendered in the Hospital. Each such ad hoc committee will keep permanent records of its proceedings and activities and submit a report of its activities to the MEC.

11.2.2. Parliamentary Procedure

All meetings of all committees and subcommittees of the Medical Staff are to be conducted following Robert's Rules of Order or a less formal implementation of the concepts included in Robert's Rules of Order.

11.2.3. Scheduling

Medical Staff committees will hold regular meetings as specified in these Bylaws, the meeting schedule of which will be reviewed and/or revised by the Chair at the beginning of each academic year. The committee members will be advised in writing, at least one (1) week in advance of scheduled meetings, of any necessary changes to the established meeting schedule. If no meeting schedule is otherwise described in these Bylaws, the committee will meet at least quarterly unless otherwise required in the description for each committee.

11.2.4. Appointment of Chairs of Committees

Standing committee chairs are appointed by the Chief of Staff except when chairs are specified in these Bylaws. Subcommittee chairs of standing committees are appointed by the Chairs of each respective standing committee. Standing committees of the Medical Staff are chaired only by Members of the Active Medical Staff or a voting Affiliated Professional member of the committee.

11.2.5. Committee Membership Appointment

Membership of each committee is appointed by the committee chair, after consultation with the Chief of Staff or Chief Executive Officer, as appropriate. The MSSD will maintain an accurate membership and attendance roster of all committees of the Medical Staff.

Active Medical Staff Members and Affiliated Professionals appointed to Medical Staff committees will have committee voting prerogatives. Individuals who are not Active Medical Staff Members or Affiliated Professionals will be appointed as non-voting committee members

unless the Chair specifies voting prerogatives at the beginning of the Medical Staff year. Any such voting prerogatives will be documented in committee minutes at the beginning of the Medical Staff year and remain in effect for the committee membership appointment period of one (1) year.

Voting privileges, if issued by the Chair, will be for all matters before the committee during the course of the year.

11.2.6. Quorum

Unless otherwise stipulated in these Bylaws, a committee or subcommittee quorum consists of at least three (3) voting committee members present at the time of the discussion or vote. For the MEC, a quorum consists of at least ten (10) or more MEC members who are Members of the Active or Affiliated Medical Staff and are present at the time of the discussion or vote.

11.2.7. Manner of Action

Having established a voting quorum, the action of a simple majority of the voting committee members present will represent the action of the committee. Action may be taken without a meeting when, in the discretion of the Committee Chair, the action is sufficiently straightforward that discussion and deliberation is not necessary. In such an event, and if there are no objections from the voting committee members, action may be taken by vote through email or similar method and upon the approval of the number of voting committee members that constitutes a quorum.

11.2.8. Attendance Requirements

Excused absences can be issued by Chairs or Chiefs if requests for absences are submitted before the scheduled meeting. Any committee may invite the attendance of any individuals who may be useful to its work. All voting committee members are expected to attend or have a designee present for fifty percent (50%) of the committee's meetings.

11.2.9. Notice of Meetings

Chairs are responsible for scheduling meetings and providing adequate notice to committee members.

11.2.10. Minutes and Reporting

A. Minutes of all meetings, unless otherwise stated, will be forwarded to the Medical Staff Services Department, which will serve as the official repository for official business of the Medical Staff. Chairs of Committees will utilize a standardized meeting minutes template maintained by the Medical Staff Services Department. (See Appendix 4.)

B. Minutes of meetings will include, at a minimum, summaries and recommendations of any and all new policies or changes in policy. Such recommendations will be submitted to the Medical Executive Committee for its approval.

C. Each committee must submit reports to MEC on its activities, including policy recommendations, per the guidelines set forth below. Each report must be approved by the committee, to include subcommittees, before being brought forward to the MEC. Such reports will be made by the committee chair, or designee if not available:

Ambulatory Care..Annually

Bylaws	No less than every two years
Cancer	Twice yearly
Credentials	Every month
Critical Care	Twice yearly
Ethics	Twice yearly
Infection Control	Twice yearly
Well Being	Twice yearly
Operating Room	Twice yearly
Pharmacy and Therapeutics	Every month
Performance Improvement and Patient Safety	Every month
Utilization Management Committee	Twice yearly
Lab Committee	Every three months

D. Minutes of all meetings of standing committees, as well as any committee addressing peer review processes, are confidential as peer review processes under Section 1157 of the Evidence Code as is all material caused to be prepared for the use of said committees. Likewise, any business before these peer review bodies must be treated with the utmost confidentiality and not be discussed or disseminated outside of the protection of the peer review body or organization except as allowed or required by law.

11.2.11. Special Meetings

Special meeting of any standing committee may be called or requested by the Chair or Chief thereof, by the Chief of Staff, or by one-third (1/3) of the committee's voting members, but not less than two (2) voting members. The agenda must be included in the call to meeting. Notice must be given in writing at least two (2) weeks in advance of such called meeting to all voting members of the committee. Only matters included in the agenda may be considered at a special meeting.

11.2.12. Terms of Committee Members

Unless otherwise specified, committee members are appointed for term of one (1) year.

11.2.13. Removal

If a member of a committee ceases to be a Member in good standing of the Medical Staff or an Affiliated Professional in good standing or suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that committee member may be removed by the Chair and Chief of Staff. Any committee member whose employment or contract relationship with the Hospital or whose membership in the Medical or Affiliated Staff ends under any provision of these Bylaws is automatically removed from membership in each committee on which they had served.

11.2.14. Vacancies

Unless otherwise specifically provided, vacancies on any committee will be filled in the same manner in which an original appointment to such committee is made, provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Chair and Chief of Staff.

11.3. **Medical Executive Committee (MEC)**

11.3.1. Composition of MEC

The MEC consists of a group of voting members and group of non-voting members.

Voting members the Officers of the Medical Staff, the Chiefs of the twenty (20) Clinical Services identified in subsection 9.1.2 herein, the Director of Health, the Chief Medical Officer of the San Francisco Health Network, the Chief Executive Officer, the Vice Dean, the Chair of the Credentials Committee, the Chief Medical Officer (CMO), the Chief of Performance Excellence, four (4) At-Large representatives (each either a Member or Affiliated Professional, with at least one Affiliated Professional) elected in accordance with these Bylaws, and up to three (3) representatives of the House Staff appointed by the Chief of Staff.

Non-voting members include the Chief Nursing Officer, an Affiliated Professional who co-chairs the Committee for Interdisciplinary Practice (CIDP), the Associate Chief Medical Officer (ACMO) of Medical Surgical Services, the ACMO of Perioperative Services, the ACMO of Critical Care Services, the ACMO of Care Coordination, the ACMO of Performance Excellence, the Medical Director of Performance Excellence and Improvement, the Chief Pharmacy Officer for the San Francisco Department of Public Health,.

The Chief of Staff may invite other persons to attend meetings.

11.3.2. Attendance and Voting

A. It is the expectation that all Members and Affiliated Professionals on MEC will attend MEC meetings and will send an alternate when unable to attend. If a Member or Affiliated Professional fails to attend fifty percent (50%) of the MEC meetings during a Medical Staff Year, the Chief of Staff may appoint an alternate to serve in that Member or Affiliated Professional's place for the following Medical Staff Year.

B. Each At-Large representative has one (1) vote.

C. When a Chief of Service cannot attend a meeting, the Chief may designate an alternate to attend and exercise a proxy vote in the Chief's absence.

D. When a Chief of Service also holds the position of an officer of the Medical Staff or serves as the Vice Dean, no additional member of the MEC will be named, and that single individual will represent both membership categories and have only one (1) vote.

E. The three (3) representatives of the House Staff will collectively have a single vote.

11.3.3. Officers and At-Large Representatives

A. The current or acting Chief of Staff will serve as the Chair of the MEC.

B. The Chief of Staff-Elect will serve a one (1) year term when elected at the annual meeting of the Medical Staff or will serve for the remainder of the unexpired term of the vacancy the Chief of Staff-Elect fills when elected by the MEC.

C. The Chief of Staff-Past will serve a one (1) year term after completion of the Chief's year as Chief of Staff.

D. The four (4) At-Large MEC representatives who are elected will not serve more than three (3) consecutive one (1) year terms. However, an At-Large representative may not be appointed to a successive term if the At-Large representative has not attended at least fifty percent (50%) of the MEC meetings during the current appointment term.

E. Vacancies in any of the four (4) At-Large representative positions arising during the Medical Staff Year will be filled by the nomination of a Member of the Active Medical Staff or Affiliated Professional by the Chief of Staff and approval by a vote of the MEC.

11.3.4. Duties of MEC

The Medical Staff delegates to the MEC broad authority to oversee the operations of the Medical Staff. Under the leadership of the Chief of Staff, and without limiting this broad delegation of authority, the MEC must perform in good faith the duties listed below.

F. Represent and act on behalf of the Medical and Affiliated Staff, subject to such limitations as may be imposed by these Bylaws;

G. Coordinate the activities of the Medical Staff committees and of the Clinical Services;

H. Receive and act upon reports and recommendations from Medical Staff Committees and Clinical Services;

I. Provide a forum in which the Medical Staff leadership can discuss issues and recommendations with the Chief Executive Officer, Chief Nursing Officer, Chief Financial Officer, Chief Medical Officer, and Vice Dean;

J. Fulfill the Medical and Affiliated Staff's accountability to the Governing Body for the quality of care rendered to patients;

K. Ensure that the Medical Staff and Affiliated Professionals are kept abreast of new laws, regulations, licensing and accreditation standards, and CMS Conditions of Participation;

L. Review the credentials of all Applicants and make recommendations to the Governing Body for Member and Affiliated Staff appointments, assignments to departments, and delineation of Clinical Privileges and Standardized Procedures;

M. Review the recommendations from the Credentials Committee and make recommendations to the Governing Body for reappointment and renewal or changes in Clinical Privileges, Affiliate Status and Standardized Procedures;

N. Ensure the professional and ethical conduct and competent clinical performance of Medical and Affiliated Staff Members , including the initiation of investigations and corrective action when warranted;

O. Review and approve all hospital-wide administrative and environment of care policies and clinical policies proposed by Medical Staff committees; and

P. Make recommendations directly to the Governing Body for its approval regarding the following:

    1) The Medical Staff's structure;
    2) The mechanism used to review credentials and to delineate individual clinical privileges.
    3) Appointment and reappointment for Medical and Affiliated Staff Members;
    4) Delineated Clinical Staff Privileges or Affiliated Status for each eligible individual;

5) The mechanism for hearing procedures and the mechanism by which Membership on the Medical or Affiliated Staff may be terminated

6) The appropriate steps associated with restrictions on Clinical Staff Privileges or Affiliated Status ; and

7) The organization of the quality assessment and improvement activities of the Medical and Affiliated Staff.

Q. To amend these Bylaws and Rules and Regulations in accordance with Article 16, in the case of a documented need for an urgent amendment necessary to comply with law, regulation, or deficiency issued by The Joint Commission or state or federal regulating body; and

R. To take such other actions as may reasonably be deemed necessary in the best interest of the Medical Staff and Hospital. The authority delegated pursuant to this subsection 11.3.4 may be removed by amendment of these Bylaws and Rules and Regulations.

11.4. **Nominating Committee**

11.4.1. Composition

The Committee will be chaired by the Chief of Staff-Past or, in years in which there is no Chief of Staff-Past, the Chief of Staff. The Chair will appoint four (4) Members from the Active Medical Staff to serve on the committee, and at least one of these appointees will be from the Community Primary Care Service and at least one (1) will be an Affiliated Professional. The Vice Dean, Chief Medical Officer, and Chief Executive Officer will also be Members of the committee.

11.4.2. Duties

The committee will act upon the following requirements:

A. Nominate a Member of the Active Medical Staff to serve as Chief of Staff-Elect prior to the end of the first year of the Chief of Staff's term of office.

B. Should the incumbent Chief of Staff be re-nominated to serve an additional year, a previous Chief of Staff will also be nominated as Chief of Staff-Past until a new Chief of Staff-Elect is nominated.

C. Nominate four (4) Members of the Active Medical and Affiliated Staff to serve a one-year term as Members-At-Large on the MEC (including at least one(1) Affiliated Professional). Members-At-Large may not serve more than three (3) consecutive years. An At-Large Member may not be appointed to a successive term if that Member has not attended at least fifty percent (50%) of the MEC meetings during the current appointment term.

D. Election of the Medical Staff Officers will occur at the Annual Meeting in accordance with subsection 8.2.2 herein.

11.4.3. Meetings

The Committee will meet as needed to carry out these duties and will maintain records of its activities and meetings.

11.5. **Ambulatory Care Committee**

11.5.1. Composition

This committee will consist of Medical Staff Members from the Clinical Services:

E. A minimum of one (1) Active Physician Member of the Medical Staff or Affiliated Professional from: Medicine, Medical Subspecialty, Family and Community Medicine, Community Primary Care (CPC), Pediatrics, Obstetrics-Gynecology, Surgical Service, and Emergency Medicine. Members of the Medical Staff from other Clinical Services may be on the committee as deemed appropriate by the Co-chairs and Chief of Staff. This may include, but is not limited to, representatives from Hospital Administration, Nursing, Information
Services, Laboratory Medicine, Pharmacy, Radiology, and Quality Management.

F. The committee will be co-chaired by an Active Member of the Medical Staff from Community Primary Care and the Associate Chief Medical Officer for Specialty Care and Diagnostics or the Associate Chief's designee.

11.5.2. Duties

The committee will:

A. Address cross-department operational issues, with a focus on communication, coordination of services, and inter-disciplinary problem solving. The committee will engage on-and off-campus primary care, medical and surgical specialty services, and diagnostic and ancillary services in identifying and addressing areas of need.

B. Serve as a forum to discuss issues related to the planning, development, quality, and delivery of integrated ambulatory care services.

C. Lead the development of Hospital policies, procedures, practices, and measurement tools that are common to department, services, and programs providing ambulatory care services.

D. Review clinic-specific practices as needed to ensure that they are aligned with the Hospital's mission and operational and organizational systems.

E. Identify opportunities to improve care in the ambulatory setting: that relate to clinical, diagnostic, or ancillary services; that relate to patient experience; or at the request of committee members or the Chief of Staff.

F. Develop and maintain a communication network for the Hospital and CPC leaders in ambulatory care.

G. Facilitate linkages and collaboration between: primary care in the sub-specialty care providers; hospital based and community based providers; and medical providers and other clinical disciplines.

11.5.3. Meetings

This Committee will meet at least quarterly but as frequently as necessary to carry out its duties and will maintain records of its proceedings and activities.

11.5.4. Reporting

This Committee must submit a written report to the MEC on its activities, including policy recommendations, annually.

11.6. **Bylaws Committee**

11.6.1. Composition

This Committee will consist of at least seven (7) Members of the Active Medical Staff including the Chief of Staff, Chief of Staff-Elect, Chiefs of Staff-Past, the Chief Medical Officer, one representative from Hospital Administration, one representative from the Dean's Office, and one representative from the CPC service. The Chair will be the Chief of Staff-Elect or co-chaired with the Chief of Staff. While Affiliated Staff Members are not voting members, they may be invited to join the committee to give input to voting members.

11.6.2. Duties

The Committee will conduct a periodic review of the Medical Staff Bylaws and Rules and Regulations no less than every two years and submit recommendations for changes to the MEC prior to any required notification of the Active Medical and Affiliated Staff.

11.6.3. Meetings

The Committee will meet at least annually but as frequently as necessary to carry out its duties and will maintain records of its proceedings and activities.

11.7. **Cancer Committee**

11.7.1. Composition

The Cancer Committee will consist of five (5) Active Medical Staff Members representing each of Diagnostic Radiology, Pathology, Medical Oncology, Palliative Care, and General Surgery. Other Members will include: the Cancer Program Administrator, an Oncology Nurse, a Radiation Oncologist, a Social Worker, a Certified Tumor Registrar, a Performance Improvement representative, someone from Clinical Research, a Genetics professional/counselor, someone from Rehabilitation Services, a Registered Dietician, and a Pharmacist.

11.7.2. Duties

The Cancer Committee will:

A. Actively supervise the Tumor Registry doing quality review of abstracting, staging, and completeness of extent of disease information. This will include ensuring that the Tumor Registry meets the standards of the American College of Surgeons and Commission on Cancer.

B. Appoint and oversee the functions of the Tumor Board, a separate, multidisciplinary, weekly consultative and education committee.

C. Perform continuous quality improvement functions for the Medical Staff with respect to cancer patients. These include working with individual Clinical Services and Hospital Administration as well as performing patient care evaluations as mandated by the Commission on Cancer.

D. Ensure that consultative services from all major disciplines are available for all Hospital cancer patients.

E. Ensure that educational programs for the Medical and Affiliated Staff include all major cancer treatment sites.

11.7.3. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities.

11.7.4. Reporting

This Committee must submit a written report to the MEC on its activities, including policy recommendations, on a twice-yearly basis.

11.8. **Credentials Committee**

11.8.1. Composition

The Credentials Committee will consist of at least eight (8) Members of the Active Medical Staff, including the Chief of Staff, an officer of the MEC, one (1) Member from the CPC service, and at least one Affiliated Staff Member of the Interdisciplinary Practice Subcommittee. Two (2) of the Members will be Chiefs or Assistant Chiefs of Clinical Services and at least one Member will be from a clinical area where surgery is practiced (Surgery, Ob/Gyn., Orthopedics, Otolaryngology, or Neurosurgery).

11.8.2. Duties

The Credentials Committee will:

F. Review the credentials of Applicants and make recommendations for membership and Affiliate Status and delineation of Clinical Privileges and Standardized Procedures in compliance with these Bylaws;

G. Make a report to the MEC on each Applicant for Medical and Affiliated Staff membership, Clinical Privileges, and Affiliate Status which will include recommendations from the appropriate Chief of Service; and

H. Review all information available regarding the competence of Medical and Affiliated Staff Members and as a result of such review makes recommendations for the granting of Clinical Privileges or Affiliate Status, reappointments, and the assignment of Applicants to the various Clinical Services as provided in theses Bylaws.

11.8.3. Meetings

The Credentials Committee will meet monthly at least ten (10) times per year and maintain a permanent record of its procedures and activities.

11.8.4. Reporting

The Credentials Committee must report to the MEC regarding approval of Medical and Affiliated Staff, which includes recommendations from the appropriate Chief of Service monthly.

11.8.5. Subcommittees

A. <u>Clinical Interdisciplinary Practice Subcommittee (CIDP)</u>

(1) Composition

The Subcommittee will consist of the Chief Nursing Officer, the Chief Executive Officer or their designees, and an equal number of Physicians appointed by the MEC and registered nurses appointed by the Chief Nursing Officer. Affiliated Staff Members who are licensed or certified in professions other than nursing will also be included in the Subcommittee.

(2) Duties

This Subcommittee will:

Review and approve standardized procedures and privileges and protocols for patient care activities of the Affiliated Staff Members in accordance with the requirements of Title 22 of the California Code of Regulations governing committees on interdisciplinary practice.

(3) Meetings

This Subcommittee will meet at least quarterly and maintain permanent record of its proceedings and activities.

(4) Reporting

This Subcommittee must report and forward recommendations to the Credentials Committee on a monthly basis regarding approval as an Affiliated Staff Member.

11.9. **Critical Care Committee**

11.9.1. Composition

This Committee will consist of: Active Medical Staff Members who are Directors or Assistant Directors of critical care units and the Emergency Department; a nurse representative from each critical care unit and the Emergency Department; and one (1) representative each from Nursing Administration, Hospital Quality Management, Post Anesthesia Recovery, and Respiratory Therapy. One (1) House Staff Member will also be invited to serve.

11.9.2. Duties

This Committee will coordinate procedures, practices, and equipment in the various emergency areas in critical care units of the Hospital and will make recommendations to the MEC regarding these and related quality of care matters.

11.9.3. Meetings

This Committee will meet monthly at least ten (10) times a year and maintain permanent records of its proceedings and activities.

11.9.4. Reporting

This Committee must submit a report to the MEC on its activities, including policy recommendations, on a twice-yearly basis.

11.9.5. Subcommittees

A. <u>Donor Council Subcommittee</u>

(1) Composition

The Subcommittee will consist of at least one representative, who is a Medical Staff Member or Affiliated Professional from each of the following areas: Critical Care; Medical

Staff; Attending Neurologist/Neurosurgeon; a nurse representative from each critical care unit; the Emergency Department; and the Medical-Surgical, Peri-Operative, and Perinatal divisions. The Subcommittee will also include a representative from the Hospital's Organ Procurement Organization (OPO). A physician will serve as Chair of this Subcommittee.

(2) Duties

The Subcommittee will:

- Review data collected by the OPO;
- Prepare reports on donor statistics for Quality Management and the Critical Care Committee;
- Review and revise Hospital policies, as needed;
- Review and discuss concerns related to the donor process; and
- Coordinate education activities hospital-wide, as needed.

(3) Meetings

The Subcommittee will meet quarterly and maintain permanent records of its proceedings and activities.

(4) Reporting

The subcommittee must report to the Critical Care Committee on a twice-yearly basis.

11.10. **Ethics Committee**

11.10.1. Composition

The Committee will consist of no fewer than fifteen (15) Members. These Members will include: representatives of the Medical and Nursing Staffs, the Critical Care Units, the inpatient and outpatient departments; representatives of Hospital Administration and the Quality Management Department; and a Deputy City Attorney. One (1) Member of the House Staff will also be invited to serve.

11.10.2. Duties

This Committee will educate the Hospital community regarding ethical principles, facilitate interchange in ethical decisions, and help develop ethical guidelines. The Committee, or a subgroup of the Committee, will also meet as needed to provide consults on specific situations or issues.

11.10.3. Meetings

The Ethics Committee will meet monthly at least ten (10) times a year and maintain a permanent record of its proceedings and activities.

11.10.4. Reporting

The Ethics Committee must submit a written report to the MEC including policy recommendations, on a twice-yearly basis.

11.11. **Infection Control Committee**

11.11.1. Composition

This Committee will consist of Members from the Active Medical Staff diverse services involved in clinical care and operations. Current members include:

A. Medical Staff:
    1. Laboratory Medicine
    2. Medicine, with expertise in Infectious Disease
    3. Medicine, with expertise in Occupational Health (when position is filled)
    4. Pediatrics
    5. Anesthesiology
B. Infection Prevention and Control Program Manager
C. Chief Quality Officer
D. Inpatient Nursing Administrative Representative
E. 4A SNF Nurse Manager
F. Outpatient Nursing Director
G. Patient Safety Officer
H. Senior Industrial Hygienist
I. Infection Control Department Members, including Infection Control Practitioners, Analyst, and Data Manager
J. Infectious Diseases Pharmacist
K. Environmental Services
L. Facilities Management
M. Occupational Health
N. Additional Ad Hoc or Consultant Members (non-voting):
    1. Sterile Processing Department Manager;
    2. Operating Room Manager; and
    3. Food & Nutritional Services Director.

11.11.2. Duties

This Committee is responsible for directing the infection control program for the Hospital and other entities covered under the Hospital license, such as on-site clinics and the 4A Skilled Nursing Facility. The Committee will: guide and help prioritize the activities of the Infection Control staff; assist with definitions and guidelines for surveillance of infections; receive reports of infection rates, clusters of infections, and outbreaks; promote a prevention program designed to minimize infection hazards; review procedures and programs for surveillance and prevention of infections in healthcare workers and other staff; and review and approve infection control policies and procedures. The Infection Control Committee may institute appropriate control measures or investigations when there is a reasonable concern of danger to patients or staff.

11.11.3. Meetings

This Committee will meet at least bimonthly and maintain a record of proceedings and activities.

11.11.4. Reporting

The Infection Control Committee must submit a written report to the MEC on its activities, including policy recommendations, semi-annually.

11.12. **Well Being Committee**

11.12.1. Composition

The Well Being Committee is comprised of no less than three (3) Active Members of the Medical and Affiliated Staff, a majority of which, including the Chair, will be physicians. Insofar as possible, members of this Committee should not serve as active participants of other peer review or continuous quality improvement committees.

11.12.2. Duties

The duties of the committee are as follows:

O. To foster and actively support the well-being of Medical Staff Members and, as appropriate and consistent with labor agreements, if applicable, Affiliated Professionals;

P. To support Chiefs of Service in addressing well-being issues among Medical Staff Members and Affiliated Professionals on their team, including faculty, staff, and trainees;

Q. To provide education to Medical and Affiliated Staff Members about illness and impairment issues specific to such Members ;

R. To facilitate self-referral by Medical Staff Members and, as appropriate, Affiliated Professionals and referral by other organization staff;

S. To facilitate referral of the affected Medical Staff Members and, as appropriate, Affiliated Professionals to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;

T. To provide for the maintenance of the confidentiality of the Medical Staff Members and Affiliated Professionals, as appropriate and consistent with existing human resources practices and labor memorandums of understanding, seeking referral or referred for assistance, except: as limited by law or ethical obligation; as allowed by these Bylaws or any labor agreement; or when the safety of a patient is threatened;

U. To assure evaluation of the credibility of a complaint, allegation, or concern;

V. To monitor the affected Medical Staff Member or Affiliated Professional and the safety of patients until the rehabilitation or any disciplinary process is completed;

W. To assure a reporting to the Medical Staff leadership in instances in which a Medical Staff Member or Affiliated Professional is providing unsafe treatment; and

X. To provide assistance, counseling, and referrals for disruptive Medical Staff Members or Affiliated Professionals

11.12.3. Meetings

The Committee will meet at least every 3 months, and more frequently as necessary. It will maintain only such record of its proceedings and activities as it deems advisable.

11.12.4. Reporting

The Well Being Committee must submit a written report to MEC on its activities, including policy recommendations, semi-annually.

11.13. **Operating Room Committee**

11.13.1. Composition

This Committee will consist of:

- Medical Staff Members representing all services performing procedures within the perioperative areas;
- The Department of Anesthesia;
- The Perioperative Nursing Director;
- The Chief of the Infection Control Committee;
- The Director of the Blood Bank;
- A representative from Hospital Administration; and
- One (1) non-voting Member of the House Staff (who will be invited to serve)

11.13.2. Duties

The Operating Room Committee is responsible for the evolution of the safe, proper, and efficient utilization of Operating & Procedural Rooms within the Hospital, including the Surgical and Procedural unit and the operating rooms in Labor & Delivery. This Committee is responsible for the development of policies and procedures regarding the safe, proper, and efficient conduct of surgical procedures.

11.13.3. Meetings

This Committee will meet monthly at least ten (10) times a year and maintain permanent records of its proceedings and activities.

11.13.4. Reporting

The Operating Room Committee must submit a written report to MEC on its activities, including policy recommendations, on a twice-yearly basis.

11.14. **Pharmacy and Therapeutics Committee**

11.14.1. Composition

This Committee will consist of at least five (5) Members of the Active Medical Staff including one (1) representative from the Community Primary Care service. In addition, representatives from the Pharmaceutical Service, the Nursing Service, Nutrition Services, Hospital Administration, Affiliated Professionals and other services as appropriate will serve with a vote. The Director of Pharmaceutical Services, or designee, will serve as Secretary to the Committee. A Member of the Medical Staff with expertise in pharmacology shall serve as Chair. The Chief Pharmacy Officer will serve as Vice Chair.

11.14.2. Duties

This Committee is responsible for the development and surveillance of all drug use policies and practices within the Hospital and its clinics. The Committee will assist in the formation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to pharmaceuticals in this Hospital and its clinics. It will also perform the following specific functions:

A. Serve as an advisory group to the Medical Staff and the Department of Pharmaceutical Services on matters pertaining to the choice of available drugs;

B. Publish and maintain the Hospital formulary;

C. Establish and maintain standards concerning the use and control of investigational drugs and of research in the use of approved drugs;

D. Make recommendations concerning drugs to be stocked on nursing units and other special services;

E. Prevent unnecessary duplication in stocking pharmaceuticals;

F. Evaluate clinical data concerning new pharmaceuticals requested for use in this Hospital and make recommendations to the MEC regarding what pharmaceuticals should be made available and placed on the formulary;

G. Review and recommend changes to medication use policies, guidelines, and standardized medication orders to ensure safe and appropriate prescribing, administration, and monitoring of medications;

H. Review and recommend changes in the electronic health record platform (*e.g.*, Epic) to improve the quality, safety, and efficiency of care delivered;

I. Review medication-related issues and content from groups including but not limited to the Clinical Decision Support Committee and the Procedural Sedation Subcommittee, and examples include review of ordersets, best practice advisories, smartsets, medication alerts, and guidelines for use;

J. Promote medication use safety; and

K. Report issues to the Performance Improvement and Patient Safety Committee.

11.14.3. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities.

11.14.4. Reports

This Committee shall submit a written report to MEC on its activities, including policy recommendations to the MEC monthly.

11.14.5. Subcommittees

The Committee will conduct the majority of its business through five (5) subcommittees. The Chair of each subcommittee will be a member of the Pharmacy and Therapeutics Committee and will be appointed by the Chair of the Committee with the approval of the Chief of Staff.

A. <u>Antibiotic Advisory Subcommittee</u>

This Subcommittee is responsible for reviewing antibiotics and related therapies. The Subcommittee will assist the Formulary Review Subcommittee in conducting drug use evaluations for antibiotic therapy. The subcommittee will work closely with the Infection Control Committee and the Clinical Laboratories.

B. Formulary Review Subcommittee

This Subcommittee is responsible for evaluating all requests for changes to the Formulary including additions of new drugs, new uses for current drugs, and deletions from the Formulary. The Subcommittee will also conduct periodic reviews of drug classes to assess appropriate use and promulgate guidelines for the use of drugs in clinical areas as appropriate.

C. Nutrition Subcommittee

The Subcommittee will recommend therapeutic enteral and parenteral nutritional formulations for the Formulary and monitor and assess nutritional therapies. Additionally, the Subcommittee will review and approve policies and procedures relating to nutritional therapy of the Food and Nutritional Service, Outpatient Nutrition Service, and the Nutritional Support Services, including the Diet Manual.

D. Pain Management Subcommittee

This Subcommittee will recommend and periodically review a program to promote effective pain management. It will collaborate with the Medication Error Reduction Plan Subcommittee around policies related to pharmacotherapy of pain. It will review and recommend policies and procedures pertinent to pain management.

E. Medication Error Reduction Plan Subcommittee

This Subcommittee will set system-wide and department-specific policies to reduce medication errors and adverse drug events. The subcommittee will review and revise the California Department of Public Health-mandated Medication Error Reduction Plan annually to assess effectiveness and identify weaknesses or deficiencies that could contribute to errors. The subcommittee will also review and report all unusual occurrences related to medications and make recommendations to the Pharmacy and Therapeutics Committee on ways to prevent such occurrences in the future.

11.14.6. Subcommittee Reporting

The subcommittees will report to the Pharmacy and Therapeutics Committee monthly.

11.15. **Performance Improvement and Patient Safety Committee (PIPS)**

This is a Joint Hospital Administration and Medical Staff committee responsible for implementing the objectives of the organization-wide performance improvement and patient safety program. The committee takes an interdisciplinary and proactive approach to the prevention of adverse events, medical errors, and near misses, and promotes patient outcomes/safety and reduction of health disparities as the core values in providing quality patient care.

11.15.1. Composition

This Committee will consist of at least seven (7) physician representatives from the Active Medical Staff. Up to three (3) additional representatives from clinical services may

include Affiliated Professionals. It will also include one (1) representative from each of Radiology, Clinical Lab, Pharmacy, Infection Prevention and Control, and Nursing. In addition, the Executive Leadership Team including the Chief Executive Officer, Chief Operations Officer, Chief Nursing Officer, Chief Pharmacy Officer, and UCSF Vice Dean will serve with one vote. The Administrative Director of Utilization Management and the Patient Safety Officer will also be Members. The Chief Executive Officer, Chief Medical Officer, or an Associate Chief Medical Officer will serve as the Chair, and the Chief Quality Officer will serve as Vice-Chair.

11.15.2. Duties

This Committee:

A. On an annual basis, reviews the effectiveness of Hospital Performance Improvement and Patient Safety Program in meeting the organizational-wide purpose, goals, and objectives and revises the program as necessary.

B. Identifies organization-wide trends, patterns, and opportunities to improve aspects of patient care and safety through the review and analysis of data obtained from focused reviews and sentinel events in the Joint Commission Sentinel Event Alerts, patient case reviews, risk management reports, hospital claims, patient and staff surveys, utilization review data, patient/visitor concerns, clinical service and ancillary/diagnostic department performance improvement reports, ongoing medical record review, and other sources as appropriate.

C. Formulates and recommends actions for improving patient care and safety to clinical services, ancillary/diagnostic departments, and performance improvement committees as appropriate.

D. Makes recommendations based on an evaluation of the care provided (e.g., efficacy, appropriateness) and how well it is done (e.g., availability, timelines, effectiveness, continuity with other services, safety, efficiency, respect, and caring).

E. Submits an annual report to the MEC.

F. Facilitates a multidisciplinary, interdepartmental collaborative approach to improving the quality of patient care and safety, and appropriate utilization of resources through the designation of Performance Improvement.

11.15.3. Meetings

The Committee will meet monthly at least ten (10) times a year. The Committee will maintain permanent records of its proceedings and activities.

11.15.4. Reporting

The Performance Improvement and Patient Safety Committee must report and forward recommendations monthly to the Joint Conference Committee through the Chief Medical Officer and Chief Quality Officer, based on the review and recommendations made by the MEC.

11.15.5. Subcommittees

The Committee will maintain and utilize the following subcommittees to do the work as described:

A. <u>Code Blue Subcommittee</u>

(1) Composition

This subcommittee will consist of physician representatives from Cardiology, Emergency Department, Pulmonary Service, and Anesthesia. Additional representatives from Respiratory, Nursing Pharmacy, Product Evaluation and Quality Management will also serve.

(2) Duties

This subcommittee will oversee the organization of the Code Blue Team (*e.g.*, personnel composition, Member's roles and responsibilities, availability of equipment, scope of service area, and communication mechanisms). All findings from codes related to quality improvement activities will be reported to this subcommittee for evaluation and recommendations.

(3) Meetings

The Code Blue Subcommittee will meet monthly and maintain permanent records of its proceedings and activities.

(4) Reporting

The Code Blue Subcommittee must submit a written report to PIPS on a once-yearly basis.

B. <u>Event Analysis & System Improvement Subcommittee (EASI)</u>

(1) Composition

This subcommittee will consist of at least eight (8) Members of the Active Medical Staff, including representatives from the Clinical Services of Medicine, Surgery, Pediatrics, Family and Community Medicine, Obstetrics and Gynecology, Psychiatry, and Emergency Medicine. In addition, representatives from Hospital Risk Management, UCSF Risk Management, Hospital Administration, Quality Management, and the Chief Nursing Officer or designee will also serve. The Medical Director of Risk Management or designee will serve as Chair for this subcommittee. The Director of Risk Management will serve as Vice Chair.

(2) Duties

The Subcommittee will:

a. Provide oversight of the quality and safety event review process;

b. Provide oversight to ensure identification of clinical risk, system vulnerabilities, and opportunities for quality improvement;

c. Ensure implementation of recommend corrective action to mitigate or eliminate future recurrence of similar events; and

d. Establish a framework that improves clinical and operational systems, patient safety, and quality outcomes using a shared accountability model.

(3) Meetings

The subcommittee will meet monthly at least ten (10) times per year and maintain permanent records of its proceedings and activities.

(4) Reporting

The Subcommittee must submit a written report to PIPS on a twice-yearly basis.

C. <u>Transfusion Subcommittee</u>

(1) Composition

This subcommittee will consist of the Nurse Manager for the Operating Room, the Nurse Manager for the Surgical Clinics, the Blood Bank Senior Supervising Technologist, the Director of the Transfusion Service/Division Chief of the Blood Bank, and one (1) Member each from the Departments of Anesthesia, Surgery, Obstetrics, Pediatrics/Neonatology, Hematology/Oncology, and Emergency Services.

(2) Duties

This subcommittee will review transfusion-related issues in the Hospital, including the appropriateness of the use of blood and blood components, blood component wastage, and all transfusion reactions. The findings of such reviews will be reported to the PIPS Committee and Chiefs of the Clinical Services, when appropriate. The subcommittee will develop and approve policies and procedures regarding transfusion practices and make recommendations based on results.

(3) Reporting

This subcommittee must submit a written report to PIPS on a twice-yearly basis.

D. <u>Trauma Program Operational Process Performance Subcommittee</u>

(1) Composition

This subcommittee will be chaired by the Trauma Medical Director, and the Trauma Program Manager will serve as Vice Chair. The subcommittee will consist of the representatives from the Departments of Emergency Medicine, Anesthesia, Neurosurgery, Orthopedics, Radiology, Physical Medicine, Rehabilitation, Respiratory Therapy, Perioperative Services, Laboratory Medicine, and Pediatrics; the Nursing Directors or Managers of the Surgical ICU, Emergency Department, Surgical Nursing, PACU, and Operating Room; Neurosurgical, Emergency Department, and Surgical CNS representatives; Risk Management and Quality Management Nursing representatives; Trauma PI Coordinators, Trauma, Orthopedic, and Neurosurgical NP representatives; the Medical Director of SFFD Emergency Medical Services Division, ZSFG Base Hospital Coordinator, EMSA Medical Director and Trauma Coordinator, and San Mateo EMS Clinical Coordinator; and other professionals who are invited to participate as needed.

(2) Duties

This subcommittee will address, assess, and correct global trauma program and system issues. The membership will review all major clinical activities and systems of trauma care and will:

a. Evaluate system and medical performance through objective and systematic monitoring;

b. Identify, analyze, and track problems;

c. Develop and implement plans for improvement, resolution, and modification of current systems of trauma care;

d. Communicate the results of reviews and plans of correction to all program related services/departments;

e. Trend and measure the effectiveness of corrective action; and

f. Document the reporting of patient safety initiatives and continuous quality improvement activities.

(3) Meetings

This subcommittee will meet on a monthly basis at least ten (10) times per year and maintain permanent records of its proceedings and activities.

(4) Reporting

The Chair and Co-Chair of the Trauma Program Operational Process Performance and Trauma Multidisciplinary Peer Review Subcommittees will submit a written combined Trauma report to PIPS on a twice-yearly basis.

E. <u>Trauma Multidisciplinary Peer Review Subcommittee</u>

(1) Composition

This subcommittee will be chaired by the Trauma Medical Director. The subcommittee will consist of the Chiefs-of-Service, or their designated representatives, of the following Departments: Surgery, Emergency Medicine, Anesthesia, Neurosurgery, Orthopedic Surgery, Radiology, Laboratory Medicine/Blood Bank, and Pediatrics. Additional members include the Co-Directors of Surgical ICU, the Hospital Director of Patient Safety and Performance Improvement, and all members of the Department of Surgery regularly participating in the care of acutely injured patients. Other attendees will include the Trauma Program Manager and Trauma Performance Improvement staff.

(2) Duties

This subcommittee will assure the equality and appropriateness of trauma care at this Hospital as it relates to performance of individual providers and the interaction between providers of different disciplines. The subcommittee will review clinical activity and outcomes (deaths, complications, errors) and will:

a. Evaluate provider performance through objective and systematic monitoring;

b. Analyze problems related to provider performance and develop plans for improvement, resolution, and modification of current practices;

c. Communicate the results of review and plans of correction to all members of the Committee and the Trauma Panel;

d. Facilitate and direct a development of clinical management guidelines or protocols for the management trauma; and

e. Measure the effectiveness of any corrective action taken or protocols generated.

(3) Meetings

The subcommittee will meet on a monthly basis at least ten (10) times/year and maintain permanent records of its proceedings and activities.

(4) Reporting

The Chair and Co-Chair of the Trauma Program Operational Process Performance and Trauma Multidisciplinary Peer Review Subcommittees will submit a written combined Trauma report to PIPS on a twice-yearly basis.

F. Tissue Subcommittee

(1) Composition

This subcommittee will consist of attending physicians from Pathology (including the Chief of Pathology) selected by the Tissue Subcommittee Chair, and other members that the Chief of Staff appoints from surgical subspecialties and other areas.

(2) Duties

a. The Tissue Subcommittee is responsible for the review of selected surgical case reports; those with pathology reports will correlate pre and post-operative diagnosis and pathology findings. Discrepancies will be presented to the Performance Improvement and Patient Safety Committee. The Tissue Subcommittee will review tissue specimens submitted to Pathology to ensure proper tissue handling and adequate completion of requisition forms.

b. The subcommittee will also make recommendations based on results.

(3) Meetings

The Tissue Subcommittee will meet as needed, but no less than twice per year, and maintain permanent records of its proceedings and activities.

(4) Reporting

The Tissue Subcommittee must submit a written report to PIPS quarterly.

G. Procedural Sedation Subcommittee

This subcommittee will oversee the administration of moderate or deep sedation and anesthesia. The activities of the subcommittee will include physician and registered nursing training and formulating policy and procedures for the administration of moderate or deep sedation and anesthesia by non-anesthesia trained personnel.

(1) Composition

The subcommittee will be Co-Chaired by the Chief of Anesthesia or designee and a nursing administrator and consist of physician and nursing representatives from all clinical services providing procedural sedation, including: Gastroenterology, Radiology, Oral and Maxillofacial Surgery, Pulmonology, Emergency Medicine, Critical Care, Women's Option Clinic, Neonatal Intensive Care Unit, Post Anesthesia Care Unit, the Cardiac catheterization lab, and the Clinical and Translational Science Institute.

(2) Duties

This subcommittee is tasked with setting systemwide and department-specific procedural sedation policy to ensure the safe delivery of procedural sedation and to meet regulatory compliance requirements for procedural sedation throughout the institution. Policies will be reviewed and revised no less frequently than every three years. The subcommittee will track audit data on a quarterly basis. All procedural sedation-related unusual occurrences will be discussed and any recommendations forwarded to the involved department.

(3) Meetings

The subcommittee will meet monthly at least ten (10) times annually and maintain permanent records of its meetings and activities.

(4) Reporting

The subcommittee must submit a written report to PIPS on a twice-yearly basis.

11.16. **Utilization Management Committee**

11.16.1. Composition

This Committee will consist of at least three (3) Members of the Active Medical Staff or Affiliated Professionals, including the Associate Chief Medical Officer of Care Coordination (or their designee), who will serve as the Chair of the committee. The Committee must include at least two doctors of medicine or osteopathy. The committee will include representation from Ambulatory Care and Behavioral Health Services. Other individuals from the clinical, administrative, and support services whose participation is deemed necessary to increase the effectiveness of the work of the committee will be invited to meetings as needed.

11.16.2. Duties

This Committee has two primary functions:

A. Provide oversight for all Utilization Management functions, and

B. Make rational and system-coordinated recommendations on the priority of clinical services and resource allocation related to clinical care based on best available evidence.

11.16.3. Utilization Data Review

The Committee will review data related to Utilization Management at least semi-annually, including, but not limited to:

- Medical necessity/appropriateness of hospital admissions and readmissions
- Medical necessity/appropriateness of continued stay and treatment authorizations
- Lengths of stay variations and timeliness of discharge
- Professional services furnished, including drugs and biologicals
- Appropriate availability and use of ancillary services
- Overuse, underuse, and timeliness in provision of services
- Therapeutic procedures
- Adequacy of medical record documentation
- Third party payer denials
- Utilization of the Tertiary Care Contract
- Contracted Health Plan utilization and cost data
- Out-of-network referral costs
- Utilization Review Plan (review and approve annually)

Review of the above data elements may be concurrent or retrospective, and may be conducted on a sample basis for cases reasonably assumed to be outliers based on lengths of stay or extraordinary high costs. The Utilization Management Committee will work closely with financial services, social services, case management, patient placement services, and the Medical

Staff to maximize appropriate utilization of resources. The Utilization Management Committee will report relevant findings to the Medical Executive Committee including problems, areas of opportunity, and actions addressed with departments, Clinical Services, Medical Staff, and other hospital entities.

11.16.4. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities. The Utilization Management Committee will work closely with relevant stakeholders (including but not limited to Patient Financial Services, Behavioral Health Services, Ambulatory Care Services, and the Medical Staff) to maximize appropriate utilization of resources. One meeting per year must be dedicated to review of the Utilization Review Plan.

11.16.5. Reporting

This Committee must submit a written report on its activities to the MEC, including policy recommendations, semi-annually.

11.17. Laboratory Utilization Committee

11.17.1. Composition

This Committee will consist of at least five (5) Members of the Active Medical Staff including one (1) representative from the CPC service. The laboratory medicine resident will be invited and encouraged to participate. In addition, representatives from the Hospital Administration as well as nursing, pathology, Infectious Diseases, and Primary Care services, Specialty Care Services, and other services as appropriate will serve with a vote. The Director of Clinical Laboratory Services, or designee, will serve as Chair of the Committee.

11.17.2. Duties

This Committee is responsible for the development and surveillance of all laboratory testing policies and practices within the Hospital and its clinics. The Committee will assist in the formation of broad professional policies regarding the selection and availability of clinical laboratory tests, their reporting structure, and the communication of newly available tests to the clinical staff. The Committee will also perform the following specific functions:

A. Serve as an advisory group to the Medical Staff and the Department of Clinical Laboratory Services on matters pertaining to the choice of available laboratory testing;

B. Evaluate clinical data concerning new clinical lab tests requested for use in this Hospital and make recommendations to the Medical Executive Committee regarding what lab tests should be made available for order in the EHR;

C. Advise clinical staff in the appropriate analysis and follow-up for specific laboratory tests;

D. Advise in relation to and determine designation status for critical lab values and modify protocols for notification of critical results;

E. Manage the approval process and utilization of laboratory tests sent to outside reference labs; and

F. Report issues to the PIPS Committee as needed.

11.17.3. Meetings

This Committee will meet at least quarterly and maintain permanent records of its proceedings and activities.

11.17.4. Reports

This Committee must submit a written report to MEC on its activities, including policy recommendations, quarterly.

ARTICLE 12. MEETINGS OF THE ENTIRE MEDICAL STAFF

12.1. Annual Meeting

An annual Medical Staff meeting will be held within sixty (60) days of the end of the Medical Staff year.

Each Member of the Active Medical Staff is expected to attend the annual meeting of the Medical Staff at least once every two years and special Medical Staff Meetings duly convened pursuant to these Bylaws.

The agenda at the annual Medical Staff meeting will be:

A. Call to order

A. Approval of minutes of previous annual or special meetings of the Medical Staff

B. Annual Reports

1) Director of Health

2) Chief Executive Officer

3) Dean, School of Medicine

4) Vice Dean

5) Chief of Staff

C. Old Business

D. New Business

E. Adjournment

12.2. Special Meetings

A. The Chief of Staff may call a special meeting of the Medical Staff at any time. The Chief of Staff must call a special meeting within ten (10) days after receipt of a written request for same signed by not less than ten percent (10%) of the Active Medical Staff and stating the purpose for such meeting. The Chief of Staff will designate the time and place of any special meeting.

B. A written or printed notice stating place, day, and hour of any special meeting of the Medical Staff must be delivered, whether personally, by electronic mail or by mail, to each Active Member not less than seven (7) days before the date of such meeting. If mailed, the notice of the meeting is deemed delivered when deposited, postage prepaid, in a United States mail addressed to each staff Member at the address appearing on the records of the Hospital. The attendance of a Member at a meeting constitutes a waiver of notice of such meeting. No business may be transacted at any special meeting except that stated in the notice calling the meeting.

C. Twenty percent **(20%)** of the Active Medical Staff constitutes a quorum for special meetings.

D. The agenda will include reading of the notice of the meeting, transaction of business for which the meeting was called, and adjournment.

12.3Voting

A simple majority of the Active Members attending either the Annual meeting or a Special meeting will determine the outcome of the vote.

ARTICLE 13. CONFIDENTIALITY OF INFORMATION; IMMUNITY AND RELEASES

13.1. Authorization and Conditions

By applying to be a Member, Affiliated Professional, or other role with the Medical Staff, as well as by applying for or exercising clinical privileges and/or standardized procedures with the Hospital, an Applicant:

A. Authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the Applicant's professional ability and qualifications;

B. Authorizes persons and organizations to provide information concerning such Applicant to the Medical Staff;

C. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under subsection 13.2.4 below; and

D. Acknowledges that the provisions of this Article are express conditions to any application described in this Section 13.1.

13.2. Confidentiality of Information

13.2.1. General

Discussions, deliberations, records, and proceedings of all Medical Staff committees having responsibility of evaluation and improvement of quality of care rendered in this Hospital will, to the fullest extent permitted by law, be confidential. This confidentiality protection includes, but is not limited to, information regarding any Member, Applicant, or Affiliated Professional, meetings of the Medical Staff, meetings of Clinical Services, meetings of committees of the Medical Staff, and meetings of ad hoc committees created by the MEC.

13.2.2. When Disclosure is Permitted

A. Dissemination or disclosure of discussions, deliberations, records, and proceedings may only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the MEC. Actions taken to address systems issues, information about corrective actions, conclusions, referrals for other investigations, and other high-level information may be shared if authorized by the Chief of Staff in consultation with the Vice-Dean, Chief Executive Officer, and/or City Attorney's Office.

B. In all other cases, access to such information and records is limited to authorized Members or Affiliated Professionals for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentially be maintained.

C. Information which is disclosed to the Governing Body or its appointed representatives in order that the Governing Body may discharge its lawful obligations and responsibilities will be maintained by that body as confidential.

D. Information contained in the credentials file of any Member or Affiliated Professional may be disclosed consistent with other provisions of these Bylaws, as required by law, or

with the Member's or Affiliated Professional's consent to other medical staffs, hospitals, professional licensing boards, or medical schools.

E. Initiation of a corrective action investigation, submission of a report pursuant to Section 805 of the Business and Professions Code to the Member's or Affiliated Professional's professional licensing organization (such as the Medical Board), and adverse actions related to medical staff membership, privileges, and/or standardizes procedures will be reported to the peer review bodies of any other component of the San Francisco Health Network in which the Member or Affiliated Professional provides patient care services.

13.2.3. Breach of Confidentiality

Effective quality of care activities, peer review, and consideration of the qualifications of Members, Affiliated Professionals, and Applicants to perform specific procedures must be based on free and candid discussions within a quality improvement process. Any breach of confidentiality of the discussions, deliberations, records, or proceedings of Medical Staff Clinical Services or committees is outside appropriate standards of conduct for Members or Affiliated Professionals, violates these Medical Staff Bylaws, and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the MEC may undertake such corrective action as it deems appropriate. In particular, and without limitation, a breach of confidentiality includes any unauthorized voluntary testimony or unauthorized offer to testify before a court of law or in any other proceeding as to matters protected by this confidentiality provision.

13.2.4. Immunity from Liability

A. For Action Taken by the Medical Staff and Hospital.
Each representative of the Medical Staff and Hospital is immune, to the fullest extent provided by law, from liability to an Applicant, Member, or Affiliated Professional for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.

B. For Providing Information.
Each representative of the Medical Staff and Hospital and all third parties is immune, to the fullest extent provided by law, from liability to an Applicant, Member, or Affiliated Professional for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an Applicant to or Member or Affiliated Professional of the staff or who did, or does, exercise clinical privileges or provide services at this Hospital.

13.2.5. Activities and Information Covered

The confidentiality and immunity provided by this Article applies to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

A. Application for appointment, reappointment, clinical privileges, or standardized procedures;

B. Corrective action;

C. Hearings and appellate reviews;

D. Utilization and quality assurance reviews;

E. Activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

F. Queries and reports concerning the National Practitioner Data Bank, peer review body or organization, or a professional licensing organization (such as the Medical Board of California), and similar queries and reports.

ARTICLE 14. CONFLICTS AND DISPUTE RESOLUTION

14.1. **Conflicts and Disputes between the Medical Staff and the MEC**

A. The Chief of Staff must convene a meeting to resolve a conflict or dispute between the MEC and the Medical Staff upon receipt of a written petition, signed by at least twenty percent (20%) of the Active Medical Staff Members, that sets forth the rule, policy, or other significant matter at issue.

B. The meeting will include up to five representatives of the Active Medical Staff selected by the petitioners and an equal number of MEC Members selected by the Chief of Staff. The meeting will be chaired by the Chief of Staff, who will not be considered as one of the MEC representatives and who will not have voting privileges at this meeting.

C. The representatives of the Medical Staff and of the MEC will exchange information relevant to the conflict and work in good faith to resolve differences in a manner that respects the position of the Medical Staff, the leadership responsibilities of the MEC, and the safety and quality of patient care at the Hospital.

D. Resolution at this level requires a majority vote of the representatives of the Medical Staff and a majority vote of the representatives of the MEC.

E. Unresolved matters will be submitted to the Governing Body for final resolution.

14.2. **Conflicts and Disputes between the Medical Staff and the Governing Body**

A. The Chief of Staff must convene a meeting to resolve a conflict or dispute between the Medical Staff and the Governing Body upon a majority vote of the MEC or petition of at least twenty percent (20%) of the Active Members. The Chief of Staff will work with the Secretary of the Governing Body to ensure compliance with public notice requirements.

B. The Medical Staff will be represented by two officers of the Medical Staff and three Active Medical Staff Members selected by the Chief of Staff. The Governing Body will be represented by the Governing Body members on the Joint Conference Committee. The Hospital Chief Executive Officer and Vice-Dean will also be invited to attend this meeting and will not have voting privileges at this meeting.

C. The meeting will be chaired by the Chair of the Joint Conference Committee.

D. The meeting participants will gather and share relevant information and work in good faith to resolve differences in a manner that respects the position of the Medical Staff, the governing responsibilities of the Governing Body, and the safety and quality of patient care at the Hospital.

E. Resolution at this level requires a majority vote of each of the following groups: (a) the representatives of the Medical Staff; and (b) the representatives of the Governing Body. Any such proposed resolution must be approved by a majority of the full Governing Body.

F. Unresolved matters must be submitted to the Governing Body for final resolution. The Governing Body will make its final determination giving consideration to the actions and recommendations of the Medical Staff, must not be arbitrary and capricious, and must act in keeping with its legal responsibilities to act to protect the safety and quality of patient care and to ensure the responsible governance of the Hospital.

ARTICLE 15. RULES AND REGULATIONS

15.1. Rules and Regulations of the Medical Staff

The Medical Staff will be governed by such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws. These will relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is to be required of each Member. Agreement to abide by the Bylaws includes agreement to abide by the Rules and Regulations. The Rules and Regulations are incorporated into these Bylaws as if set forth herein. In keeping with The Joint Commission guidelines, ammendments to the Rules and Regulations are delegated to the Medical Executive Committee (MEC).

15.2. Rules and Regulations of the Clinical Services

Each Clinical Service must formulate its own rules and regulations and proctoring protocol for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations must be consistent with these Bylaws. Substantive changes must be reflected in the biennial clinical services report to the Medical Executive Committee and approved by the MEC and the Governing Body.

ARTICLE 16. ADOPTION AND AMENDMENT

16.1. Medical Staff Responsibility

16.1.1. Initial Responsibility

The Medical Staff has the initial responsibility and authority to formulate, adopt, and recommend Medical Staff Bylaws and amendments thereto, which will be effective when approved by the Governing Body. Such approval must not be unreasonably withheld. This responsibility will be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interests of providing quality and efficient patient care and maintaining a harmony of purpose and effort with the Governing Body. Neither the Governing Body nor the Medical Staff may unilaterally amend the Medical Staff Bylaws.

16.1.2. Hospital Chief Executive Officer

The Hospital Chief Executive Officer must be consulted as to the impact of any proposed Bylaws amendments on Hospital operations and as to the feasibility of proposed amendments. The Hospital Chief Executive Officer may also develop and recommend Bylaws amendments to the Bylaws Committee or MEC for consideration.

16.1.3. Proposed Amendments

Proposed amendments will be reviewed and considered at a meeting of the Joint Conference Committee prior to distribution to the Medical Staff for a vote. The Governing Body Members of the Joint Conference Committee have the right to have their comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

16.2. Amendments

The City Attorney's Office serves as counsel for the Medical Staff in relation to any amendments and will provide input on suggested amendments to these Bylaws.

The MEC will vote on the proposed amendments and upon an affirmative vote of a majority of a quorum must submit the amendments to the Active Medical Staff for approval or disapproval as set forth in Section 16.3 herein.

Upon a petition signed by at least twenty percent (20%) of the Active Medical Staff, amendments to these Bylaws and Rules and Regulations may be submitted to the Medical Staff and the Governing Body (and without the approval of MEC) for a vote. In such an event, the proposed amendments will be reviewed and considered at the next regularly scheduled meetings of the MEC and Governing Body prior to distribution to the Medical Staff. The MEC and the Governing Body have the right to have their comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

16.3. **Method**

16.3.1. Combined

The Medical Staff Bylaws may be adopted, amended, or repealed by the following combined action:

A. The affirmative vote of a majority of the Active Members of the Medical Staff who cast votes on the matter, provided at least fourteen (14) days advance notice accompanied by the proposed Bylaws or amendments (such notice and voting may be conducted electronically); and

B. The affirmative vote of a majority of the Governing Body.

16.3.2. Governing Body Vote

The Governing Body must vote on proposed amendments within forty-five (45) days from the date of receipt. If the Governing Body does not approve the proposed amendments, it must specify its reasons in writing and forward them to the Chief of Staff, the MEC, and the Bylaws Committee.

16.3.3. Approval of Amendments

Amendments must be approved by both the Medical Staff and the Governing Body before they take effect, excepting the situations set forth in Sections 16.4 and 16.5 herein.

16.4. **Corrections**

The MEC has the power to approve corrections, such as reorganization or renumbering of the Bylaws, or correcting punctuation, spelling, or other errors of grammar or inaccurate cross-references. Such amendments are effective immediately and are permanent. The action to make such corrections must be taken by motion and acted upon in the same manner as any other motion before the MEC. Substantive amendments are not permitted pursuant to this Section.

16.5. **Urgent Amendments**

In the case of a documented need for an urgent amendment to these Bylaws and Rules and Regulations necessary to comply with law, regulation, or deficiency issued by the Joint Commission or state of federal regulating body, the Rules and Regulations may be amended for

that sole purpose by a two-thirds (2/3) affirmative vote of the MEC and by an affirmative vote of each Governing Body representative on the Joint Conference Committee. In such an event, the amendment must be submitted to the Medical Staff and Governing Body for retrospective review and approval, through the process outlined in this Article. This process must be initiated within 60 days of the Joint Conference Committee vote described in this Section. Per guidelines of The Joint Commission, Urgent Amendments to the Bylaws must follow the standard process for Bylaws Amendments as set forth in Articles 16.2 and 16.3 of these Bylaws. If there is a dispute regarding such an amendment, the Medical Staff may pursue the conflict management process set forth in Article 14 of these Bylaws.

ARTICLE 17. MISCELLANEOUS PROVISIONS

17.1. **Notice and Duty to Advise of Contact Information**

Each Member, Affiliated Professional, or Applicant has an ongoing, affirmative duty to ensure that the MSSD has accurate contact information, including email address, personal telephone number, and mailing address, for that Member, Affiliated Professional, or Applicant. This duty includes the duty to promptly (within five (5) business days) update the MSSD of any changes to that contact information. For UCSF faculty or employees, the UCSF email address is considered to be the current contact information, although a Member, Affiliated Professional, or Applicant may provide an alternative/secondary email to the MSSD to use as well. For City employees, the City-provided email address is considered to be the current contact information, although a Member, Affiliated Professional, or Applicant may provide an alternative/secondary email to the MSSD to use as well.

Except in relation to Notice related to Articles 6 and 7, above, any notification or other communication required by these Bylaws to be given by email is considered delivered when sent, and there is no obligation to ensure that such email is received or read by the Member, Affiliated Professional, or Applicant. However, if the MSSD receives a notification that an email is undeliverable, the MSSD will, within five (5) days, attempt to contact the Member, Affiliated Professional, or Applicant to obtain an accurate email address and/or to send the notification or other communication through alternative means to ensure the Member, Affiliated Professional, or Applicant learns of the issue.

17.2. **Sharing of Information for Disciplinary and Other Investigatory Purposes**

During the course of Medical Staff processes outlined by these Bylaws, information may be obtained or disclosed that requires additional investigation outside of Medical Staff processes. By way of example and without limitation, information may be learned that relates to: unprofessional conduct of Hospital staff or people in other City or UCSF departments; alleged discrimination, harassment, or retaliation; patient privacy violations; patient abuse; an unsafe work environment; misuse of public resources; mistreatment of patients or other staff; fraudulent billing or other medical practices; medical malpractice; or other ethics or civil or criminal law violations. In each instance listed above, and in other instances as determined by the Chief of Staff or by any Medical Staff committee member or subcommittee member that learns such information, the Medical Staff, through the Chief of Staff or MSSD, must notify the Hospital Administration and the City Attorney's Office of the nature of the allegations or information within seven (7) days of learning such information in order to allow Hospital Administration and the City Attorney's Office to determine if a referral needs to be made to City and/or UCSF

Human Resources departments, other City and/or UCSF departments, or law enforcement for a separate investigation for potential discipline or other purposes. Such disclosure may also be required by law or by Hospital, City, or UCSF policies or rules. The City Attorney's Office must be consulted if there is any question about what kind of information is to be disclosed.

In addition, there may be instances where parallel review or investigations occur related to the kinds of incidents or alleged misconduct listed in this section. By way of example, an incident might be submitted via a Safety And Feedback Events (SAFE) report (maintained by the Quality Management Department) that initially necessitates review by Risk Management, and the underlying information may quickly result in a referral for concurrent review by the Medical Staff, DPH or UCSF Human Resources, and/or the DPH Office of Compliance and Privacy Affairs. In the process of the investigation, the flow of information associated with these concurrent reviews can be complicated, and the City Attorney's Office should be consulted as early as possible to help ensure information only flows in the directions authorized by law and by DPH and Hospital policies. Each of these processes may result in a separate outcome, with distinct recommendations or action. Also, appropriate coordination between these separate processes can help ensure timely action that can correct issues that lead to errors, allow for improvement of clinical practice, result in appropriate regulatory reporting, and when needed result in disciplinary or other corrective action.

17.3. **Notice to MSSD and City Attorney's Office of Investigation by Professional Licensing Entity**

In the event that any Member or Affiliated Professional is given notice that the Member or Affiliated Professional is under investigation by any entity that has responsibility for issuance or oversight of the Member's or Affiliated Professional's professional license or certification (such as by the Medical Board of California, the Osteopathic Medical Board of California, or any other similar entity), the Member must give notice of such investigation within seven (7) days of learning of the investigation to the MSSD and the City Attorney's Office. Any request for medical records of any Hospital patient associated with any such investigation must be given to Hospital Health Information Systems for processing. In addition, the Member or Affiliated Professional must also promptly notify (within seven (7) days) the MSSD and City Attorney's Office any decision or action against the Member's or Affiliated Professional's license or certification by the entity conducting the investigation.

17.4. **Notice to MSSD and Chief of Service Regarding Action Against Privileges at Another Institution and Any Other Disclosable Event Related to Application/Reapplication for Privileges**

In the event that any Member or Affiliated Professional is given notice that their privileges have been suspended, restricted, or terminated at another institution for any amount of time, including voluntary acceptance of a suspension, restriction, or termination, for a medical disciplinary cause or reason, the Member or Affiliated Professional must inform the MSSD and the Member's Chief of Service within seven (7) days.

In the event that any Member or Affiliated Professional is the subject of any action listed in this paragraph, the Member or Affiliated Professional must inform the MSSD and the Member's Chief of Service within seven (7) days of the occurrence of that action or item. The items that are reportable to the MSSD and the Member's Chief of Service include all of the following:

A. Actions related to the person's liability for or insurance coverage related to their professional activities, including: actions, arbitrations, claims, or lawsuits related to the provision of patient care; reporting of any professional liability claim to an insurance carrier; the making of any settlement, arbitration, decision, or judgment in any professional liability case in which the person or their insurer had to or agreed to make any monetary payment; denial, cancellation, or the threat of denial or cancelation of professional liability insurance coverage; or being named as a defendant in a malpractice case and then being dropped from the case.

A. Actions related to or that could impact patient care, including filing, withdrawal, or completion of any administrative, government, or court case or hearing involving allegations that the provider: failed to comply with laws, statutes, regulations, or other legal requirements related to the practice of their profession or provision of services to patients; violated of any criminal law (excluding minor traffic violations); was liable for any injury caused by the person's negligent or willful act or omission in rendering services; or was challenged or sanctioned regarding the person's admission, treatment, discharge, charging, collection, or utilization management related to patient care.

B. Actions or investigation (whether undertaken, pending, or completed) involving the denial, revocation, suspension, reduction, limitation, probation, non-renewal, or voluntary or involuntary relinquishment of the provider's: medical or affiliated staff membership at any facility; medical or affiliated staff privileges at any facility; provision of clinical care for ninety (90) days or more; status as a student in good standing in any program related to clinical practice; membership or fellowship in any local, county, state, regional, national, or international professional organization; faculty position or membership; specialty board certification; license or certificate to practice any profession in any state, country, or jurisdiction; or Drug Enforcement Administration or other controlled substances registration.

C. Any issue that impairs or could impair the person's ability to carry out their professional obligations in a manner that meets the standards of care in the community, under these Bylaws, or in relation to other Hospital policies, including: any physical or mental health condition or status; any communicable health conditions that could pose a significant health and safety risk to patients; or chemical dependency or substance abuse that might adversely affect the provider's ability to competently and safely perform the essential functions of a practitioner in their area of practice.